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THE EMERGENCY ROOM CRISIS: THE IMPACT ON DRUG ABUSE

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

SEPTEMBER 28, 1990

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CONTENTS

	Page
Opening statement of:	
Hon. Charles B. Rangel	1
Hon. Lawrence Coughlin	2
Hon. James H. Scheuer	2
Hon. Michael G. Oxley	4
Hon. Benjamin A. Gilman	5
Testimony of:	
Dr. Arthur Kellermann, National Association of Public Hospitals, Director of Emergency Medicine, Regional Medical Center, Memphis, TN	6
Dr. Lynn Richardson, American College of Emergency Physicians (Harlem Hospital)	10
Dr. J. Emilio Carrillo, President, New York City Health and Hospitals Corp	34
Dr. Michelle Reisner, Director of Emergency Services, Jersey City Medical Center	38
Mark Chastang, Executive Director, D.C. General Hospital	41
Prepared statement of:	
Hon. Charles B. Rangel	59
Dr. Arthur L. Kellermann	63
Dr. Lynn Richardson	70
Dr. J. Emilio Carrillo	87
Dr. Michelle Reisner	98
Mark Chastang	103

THE EMERGENCY ROOM CRISIS: THE IMPACT ON DRUG ABUSE

FRIDAY, SEPTEMBER 28, 1990

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m. in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (chairman of the select committee) presiding.

Present: Representatives Charles B. Rangel, James H. Scheuer, Frank J. Guarini, Walter E. Fauntroy, Kweisi Mfume, Lawrence Coughlin, Benjamin A. Gilman, Michael G. Oxley, Christopher Shays, Bill Paxon, and Bill Grant.

Staff present: Edward H. Jurith, staff director; George Gilbert, staff counsel; Rebecca L. Hedlund, professional staff; James Alexander, press officer; Michael J. Kelley, staff counsel; Robyn Rosenblum, professional staff; William S. Smith, minority staff director; Richard Baum, minority professional staff.

Mr. RANGEL. Good morning.

I am Charles Rangel, the Chairman of the House Select Committee. I want to welcome those of you who are here for the Congressional Black Caucus weekend, and also to indicate the importance of this morning's hearings as we review the crisis that exists in our emergency rooms throughout these United States.

Several years ago when the crack epidemic became known, many people came to us and said that problems will be caused at the work place, in our schools, throughout our communities, and indeed in our emergency rooms.

When we talk about emergency rooms, we are not just talking about drug overdoses. We are not just talking about the violence that is connected with the drug trafficking, we are not just talking about the health problems of the poor.

We are talking about a small number of dedicated health providers, including nurses and doctors, attempting to take care of emergencies as we find the place being besieged with all types of people in need of health care and the ever-growing number of illnesses that are associated with drug abuse. Therefore, we are talking about kidney and liver and heart and respiratory diseases, and we are talking about the growing number of poor people who use emergency rooms as their only source of health care.

Let me make this clear, that we are not just talking about the reduction of quality services for poor people. We are talking about anyone who may need the services of an emergency room not being

able to get those services because they are gradually becoming a place that provides more than they originally were intended to provide, burning out professional and nonprofessional staff.

We have a list of witnesses, of people who are indeed from the MASH type of combat teams in hospitals around our country, and before I call them, I would like to introduce my distinguished colleague and the minority leader of this committee, and my partner in the work that we do, from Pennsylvania, Larry Coughlin.

[The statement of Chairman Rangel appears on p. 59.]

Mr. COUGHLIN. Thank you, Mr. Chairman.

I want to commend you for holding this hearing today. Once again, you are demonstrating your leadership by exploring a topic that demonstrates how the scourge of drugs has a devastating impact on many communities which make up our Nation.

On that note, just let me take a moment to tell those here that Chairman Rangel is one of the most tireless soldiers in the war against drugs. No number of meetings is too great, no point of travel is too far, no amount of hard work is too great if the Chairman feels it will make even a small difference in the war on drugs.

If it takes a strong press release to do the job, he will do it. If it means hard work behind the scenes in which he gets no credit, he will do that, too. Mr. Chairman, we are lucky to have you on the job.

Mr. RANGEL. Thank you.

Mr. COUGHLIN. There have recently been some promising signs in the war on drugs. Greater numbers of young people are turning away from drugs. I was recently heartened to read in a recent article in the New York Times that in many neighborhoods of our country, crack users or crack heads, as they are called, are the objects of scorn and contempt by younger kids.

The Federal Government is doing all it can in the war against drugs, but I believe it will be the changes in the hearts of individual Americans, such as the hardening attitude of these young Americans, which will win the drug war.

In the area of drug-related emergency room admissions, after years of skyrocketing statistics, the last two quarters have witnessed drops in such admissions. Unfortunately, there are areas of our country where these statistics give little hope.

The violence caused by drug trafficking and the physical harm caused by drug use remains at unacceptably high levels. These symptoms of our Nation's scourge have strained many hospitals and trauma units. I am anxious to hear about the concerns of our witnesses today and look forward to their suggestions for reform.

Thank you, Mr. Chairman.

Mr. RANGEL. Thank you, Mr. Coughlin.

We are pleased to have with us James Scheuer, a fighter in this drug war over several decades. Mr. Scheuer?

Mr. SCHEUER. Mr. Chairman, all kidding aside, and very seriously, this is a very critically important hearing. I want to thank you for your leadership.

I am Congressman Jim Scheuer. I am proud to be a Member of this panel. I congratulate our Chairman, Congressman Charles Rangel of New York for his leadership in setting up this critically important hearing on the inundation and the overwhelming of our

emergency room facilities across the length and breadth of this country.

That inundation of people into the emergency rooms is symbolic of some gross failures of our society. About 70 percent of all emergency room cases are drug-related and violence related.

All stemming from our inability and our unwillingness to do the things and to fund the programs and to make the investments in our young people that will set them on the pathways to success and not to failure. We don't educate our kids, we don't give them a proper infant health care. We don't give their mothers prenatal and postnatal health care, so the kids tend to be undernourished, to be afflicted with all kinds of sicknesses that impede their development.

We don't put them in Head Start Programs. Less than one in five kids who ought to be in enriched preschool child development program is in it, and the other four-fifths get neglected by our society. When they come into the schools, we don't give them the drug education programs that will help them be aware that drugs and drug addiction threatens their school career, their job career, their family prospects and even their very lives.

So we neglect our kids from the point of view of education services, from the point of view of health services. We don't have a national health program, and that means that 37 million Americans are cut out and deprived of our health care system.

We don't give them normal access to our health care system. We are the only developed country in the world except South Africa that treats its poor in such a disgraceful State, so what happens?

Their one point of access to health care is the emergency room, so they use the emergency room as their family doctor. These facilities that are meant for trauma, that are meant for life saving emergencies, these high tech emergency care facilities are inundated with mothers who have a kid with colic, for stomach aches, for fevers, things that regular visits to a doctor would prevent.

It is a bloody disgrace. The great fault, of course, is the failure to prepare our kids for success in school. That means child care programs, that means Head Start. The kids who have had a Head Start experience are twice as likely to finish school without involvement in drugs and violence, they are twice as likely to go on to college as kids that haven't had an enriched preschool experience.

Kids who have not had Head Start, who have not had access to Head Start, are twice as likely to end up on welfare, are twice as likely to be young teenage mothers out of wed lock, are twice as likely, the young men, to end up in the field of crime, so the inundation of our emergency rooms is symbolic of a whole vast array of failures in our society to treat our low-income populations decently, our minority populations decently, and above all, our kids decently.

It is a crying disgrace, and this hearing is a major thrust toward giving us an enriched national understanding of the painful way in which we are changing our youth, particularly our low-income and minority youth.

Thank you, Mr. Chairman.

Mr. RANGEL. No one could have said with more clarity how important it is to hear our witnesses. We will next hear from Chris

Shays from Connecticut, an outstanding Member of Congress and the Committee.

Mr. SHAYS. Thank you, Mr. Chairman.

I just want to thank you for conducting these hearings to thank our witnesses for coming, and just to add my voice to that of my Ranking Member in complimenting you for your work to help resolve the drug abuse problem throughout this country.

Mr. RANGEL. Thank you, Chris. Mike Oxley, who has a long history in law enforcement as well as a brilliant legislative career, is recognized.

Mr. OXLEY. Thank you, Mr. Chairman.

I want to welcome our witnesses today. This is not just a large city problem, although it does tend to be focused on the major cities, but clearly even towns in my district, Mr. Chairman, the size of Lima and Mansfield with 50,000 people have experienced some real difficulties in the emergency room area related to drug overdoses.

Those kind of cases certainly highlight what we will hear today. We look forward to the testimony. I notice that we have people from Memphis, from Harlem, from Jersey City, from the Nation's Capital here in Washington, but I just wanted the Chairman to know that there are other areas that clearly have that problem, though not to the extent, obviously, as the major cities, but at least enough that the public is becoming more and more aware of that.

I was pleased as you were, Mr. Chairman, that recent statistics would indicate that perhaps the crisis has abated at least a little bit in terms of overdoses as it relates to crack and to some other drugs in the emergency room area, and perhaps these witnesses will be able to put the light on that a little better.

At least the statistics were encouraging to read in the papers and to hear Mr. Bennett talk about it. Maybe we have leveled off a bit, but that doesn't negate the fact that we are clearly in a crisis proportion in some of the major cities.

We look forward to the testimony. I yield back the balance of my time.

Mr. RANGEL. I agree with everything you say, Mike.

I hope we do get into the question of reports that overdoses have been reduced generally throughout the United States. Well, the next two witnesses are in part responsible for these hearings because I visited with them not too long ago, long before the Time Magazine article where they graphically illustrated to me the problem that I was having was not with my inner city hospital, not with Harlem Hospital, but was indeed a national problem.

As a result we have started a 20-Member Congressional Caucus, Mike, just to deal with the problems of the emergency room. The caucus is a cross-section of rural, suburban, and inner city hospitals which we hope to update periodically as to what improvement's can be made. We also have the energy and commerce bill that we think will provide some relief once it is properly funded, and, so Dr. Lynn Richardson, who is from my Harlem Hospital set up the appointment.

She will be testifying along with a representative of the National Association of Public Hospitals, Dr. Arthur Kellermann. Stephanie

Kennan, the Legislative Representative for the American College of Emergency Physicians is also with us.

I want to thank you, Dr. Richardson, not only as a constituent but certainly coming from the hospital that I have said should be the flagship of public hospitals throughout the Nation. Thank you.

We have what we call a 5-minute rule. We see how that works because, as you can see, from the interest of the Members, they are very anxious to ask questions and your entire statement, if there is no objection from Members of the Committee, will be entered into the record.

Mr. RANGEL. Could I make a brief opening statement? Yes; I did not know Ben Gilman and Bill Grant from Florida had joined us. The Chair will yield to both of them.

Mr. Gilman.

Mr. GILMAN. I thank you, Mr. Chairman. I want to thank you for arranging this meeting today. I would like to welcome our panelists before this Select Committee, Dr. Kellermann of the National Association of Public Health, and Dr. Lynn Richardson of the American College of Emergency Physicians, and Dr. Emilio Carrillo, President of the New York City Health and Hospital Corp., and Dr. Michelle Reisner, Director of Emergency Services, Jersey City Medical Center and Mr. Mark Chastang, Executive Director for the D.C. General Hospital.

As members of this Select Committee we are keenly aware that the problem of drug abuse has taken on epidemic proportions in our Nation. Our emergency room statistics today certainly substantiate that, unfortunately, drug abuse is creating a whole new set of problems for our emergency room staffs across the country.

A recent survey indicated that 65 percent of emergency rooms have overcrowding that causes a moderate to severe impact on quality emergency care in their hospitals. Among the recent problems associated with emergency room overcrowding is the increased incidence of contagious diseases which spread rapidly through such crowded quarters.

Mr. Chairman, it is sad but true that the scourge of drugs in our Nation has affected many facets of our communities. However, in the case of emergency room treatment if we don't compensate for the overcrowding, ER's in turn will not be able to accommodate drug-related and other emergencies. We are going to have to understand the dynamics of the crisis facing our ER's and work to help before the drug problem and other health risks escalate geometrically, so I welcome our panelists.

We look forward to their expert testimony. Maybe they can suggest some recommendations that we could adopt that would be helpful. Thank you, Mr. Chairman.

Mr. RANGEL. Thank you, Mr. Gilman.

Mr. Grant.

Mr. GRANT. Thank you, Mr. Chairman.

No statement.

Mr. RANGEL. Thank you for coming with us today.

Dr. Kellermann.

STATEMENTS OF DR. ARTHUR KELLERMANN, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS, DIRECTOR OF EMERGENCY MEDICINE, REGIONAL MEDICAL CENTER, MEMPHIS, TN; AND DR. LYNN RICHARDSON, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS (HARLEM HOSPITAL)

Dr. KELLERMANN. Mr. Chairman, thank you for the opportunity to speak this morning. I am Dr. Arthur Kellermann, Director of the Emergency Department at the Regional Medical Center at Memphis, the only hospital in Memphis and Shelby County, TN, committed to caring for all in need without regard for their ability to pay.

I speak today on behalf of the National Association of Public Hospitals and the millions of patients who will receive care in emergency departments this year.

NAPH consists of approximately 90 public and nonprofit hospitals that serve as major referral centers, teaching hospitals and hospitals of last resort, safety net hospitals for the poor in most of our Nation's largest metropolitan areas.

NAPH member hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they provide many unprofitable specialized services; they are extremely dependent upon governmental sources of revenue—local, State, and Federal—and typically have a much lower proportions of private insured patients.

My emergency department receives and treats roughly 70,000 patients each year. Once evaluated and stabilized, many of these ED patients have to be held in my department for variable periods of time because no vacant ward or intensive care unit beds are available.

Stays of 12 hours or longer are commonplace, and stays of 24 hours or longer are not unusual. In my emergency department, privacy is nonexistent. Bed pans serve as rest rooms. Visits have to be severely restricted and meals arrive cold. When overcrowding is severe, my staff physicians have been known to intubate drug overdose patients, pump their stomachs, wean them off the respirator, and eventually discharge them without the patient ever having seen an inpatient bed.

Every day I send patients home that I would much rather keep in the hospital. Every day I have to badger my inpatient colleagues to send patients home before they are ready to leave. When overcrowding reaches the point that we cannot care for additional emergency department patients safely, we have no choice but to try to divert incoming ambulances to neighboring private hospitals.

Born in desperation, ambulance diversion can compromise a community's emergency medical system by forcing ambulances to transport patients far outside their normal call areas. This rarely accomplishes much, since many private community hospitals are almost as overcrowded as we are.

In fact, in the past 3 months alone, five private hospitals in Memphis also requested ambulance diversion at various times. Mr. Chairman, I hope today to convince the members of your committee and your colleagues in Congress of three fundamental facts about hospital and emergency department overcrowding.

First, although overcrowding in New York City is particularly severe, overcrowding is not limited to New York hospitals or institutions in the northeast corridor.

Second, overcrowding is no longer limited to public hospitals which care for the poor and the uninsured. Many of our Nation's premier private teaching hospitals are experiencing problems every bit as severe as those confronting our Nation's public hospitals.

Third, and this is very important, although drug abuse, drug-related violence, and drug-related health problems are a major contributor to this steadily growing demand for care in the United States, drugs are only one of a number of factors that are combining to threaten the fundamental nature of our Nation's emergency care system.

Now, this last observation should not be construed to mean that I do not consider drugs and drug abuse to be a problem for my hospital. In the first 6 months of 1990 alone, a selected group of expectant mothers screened at the regional medical center at Memphis acknowledged or tested positive for cocaine or other drugs.

More than 17 percent of these patients were still actively using drugs at the time of their delivery. As a result, 261 babies in our newborn center were born during this period of time to drug addicted mothers. The Director of our Trauma Center estimates that 20 percent of his monthly admissions are victims of drug-related violence or unintentional injuries sustained as a result of drug intoxication.

Although overdose patients with direct effects of cocaine toxicity and other drugs account for between 40 and 60 emergency visits to my E.D. each week, these patients represent less than 5 percent of our weekly total of visits.

Comparable figures to these have also been reported by other NAPH member institutions. However overdose statistics such as these illustrate the difficulty of interpreting the drug surveillance data that has recently been cited.

Many emergency department charts—the source of data for the drug abuse warning network and other surveillance systems—often omit mentions of drugs when the case involves trauma or other indirect effects of drug abuse. In most hospitals, cases of indirect drug abuse or indirect complications of drug abuse account for far more drug-related emergencies than overtly labeled overdose cases alone.

Although the impact of drug abuse in America's emergency departments is profound, drugs are only one of several factors that have contributed to the problem of E.D. and hospital overcrowding nationwide.

In 1980 nobody could have predicted the staggering impact that AIDS would have on our Nation's acute care hospital. Few believed that our patchwork care of health care programs for the poor, the elderly and the uninsured would fray so quickly or that millions of additional patients would come to utilize emergency departments as their sole source of medical care.

In the past 5 years many hospitals have chosen to opt out of trauma care systems and some hospitals have closed their emergency departments entirely. In addition to these problems, growing career opportunities for women, long hours and relatively low sala-

ries have aggravated an already severe shortage of practicing nurses.

In virtually every city in this country, entire hospital floors and intensive care units lie vacant because hospitals cannot recruit enough nurses to staff them. In the fall of 1988 the National Public Health and Hospitals Institute joined forces with the University of Tennessee to conduct a survey of the member institutions of the National Association of Public Hospitals and the Council of Teaching Hospitals.

Collectively these two organizations represent virtually all of our Nation's leading public and private teaching hospitals. Among responding institutions, 38 percent reported that overcrowding periodically requires them to hold admitted emergency department patients 12 or more hours beyond the time normally required for their evaluation and admission. More than one in four sometimes hold admitted patients in their emergency department for 24 hours or longer.

Although few E.D.'s are staffed and equipped to provide ongoing critical care, 27 percent of the hospitals that responded to our survey reported that they sometimes have to hold admitted intensive care unit patients in their emergency departments for 12 or more hours beyond the time normally required for stabilization due to the lack of vacant ICU beds. Nineteen percent periodically held ICU patients in their E.D.'s for 24 hours or longer.

During a single reference month, August 1988, 30 percent of responding hospitals refused inter hospital transfers due to overcrowding at least once, one-third transferred patients to other hospitals due to overcrowding, and 40 percent diverted selected ambulance patients, such as critical care cases, at least once during the month. Twenty-two percent diverted all incoming ambulances at least once during the month.

Of note, private teaching hospitals reported rates of overcrowding comparable to those reported by the public hospitals that responded to this survey.

Despite such desperate measures, the cost of emergency department overcrowding appears to be high. Sixty percent of the public and private hospital emergency department directors who responded to this survey believe that overcrowding is having a moderate to severe adverse impact on their quality of emergency care. It is also important to note that this survey was based on data collected in 1988, 2 years ago.

In many cities the problem is much worse now than it was then. Immediate steps need to be taken to begin to correct the imbalance of supply and demand as it relates to the provision of emergency treatment in acute inpatient care. NAPH supports the recent recommendations of the American College of Emergency Physicians Task Force on Hospital and E.D. overcrowding. These include the following: First, reform prospective payment reimbursement to remove financial disincentives for hospitals providing emergency care; second, where needed, we have to increase the system's capacity to provide critical care, inpatient treatment, and nursing home services; third, we must expand the supply of nurses. Nurses are the backbone of health care in this country, and the demand for nurses—especially those who provide inpatient and critical care—

far exceeds supply. The Federal Government and the States need to support initiatives to train more nurses through scholarships and grants in aid and support efforts to relieve nurses of the crushing burden of paperwork. Also, nurses must be paid more. Along with teachers, nurses are the most underpaid professionals in America. Fourth, we must support access to primary care services and support initiatives to prevent serious illnesses and injuries. Although utilization of emergency departments for nonemergency problems clogs waiting rooms, it does not cause E.D. overcrowding. However, better access to primary and preventative care services can prevent many illnesses from reaching the point where expensive emergency department care or hospitalization is necessary. Each year trauma kills 142,000 Americans, permanently disables 80,000 more, and costs society $44 billion in health care costs. If the Federal Government required all States to adopt mandatory seat belt and motorcycle helmet laws, lowered speed limits back to 55, and directed more funds to support research and pilot programs to prevent injuries, we could save more lives, prevent countless injuries, decrease costly hospital stays, and save billions of dollars in health care costs each year.

Finally, we must provide a basic level of health insurance or health care for all citizens. Half the patients who prevent to the triage desk of my emergency department either have no source of care or identify my emergency department as their family physician. Of the 70,000 patients treated in my E.D. each year, only 8 percent have private insurance. Medicare covers 10 percent, and Medicaid covers 24 percent. The remaining 58 percent are uninsured.

Mr. Chairman, hospital and emergency department overcrowding is real. It cannot be ignored, wished away or left off our master list of national priorities. When a major injury occurs or critical illness strikes, everybody wants and everybody expects to receive top quality emergency care.

Unfortunately, as our Nation's emergency departments and trauma centers fill to capacity, no one can safely assume they will get timely access to emergency care when they need it, regardless of their wealth, insurance coverage, or political connections. The alternative to tackling this problem is to do nothing, and that may be a tempting proposition in light of Gramm-Rudman looming over our heads. But such an approach will lead to disaster.

Public hospitals cannot continue to absorb massive financial shortfalls without dire consequences. Please, please resist the temptation to fix this problem by simply passing rules or regulations to forbid us from holding sick and injured patients in our emergency departments. When our hospitals are full to capacity and no alternatives are available, such rules will have the same effect as a law ordering me to save shoe leather by walking 4 feet off the ground. It simply can't be done.

Emergency physicians, nurses, and the hospitals in which we work are committed to providing the care our patients need. But we have got to have the facilities and the means to accomplish the task. Thank you.

[The statement of Dr. Kellermann appears on p. 63.]

Mr. RANGEL. Thank you. Before I recognize Dr. Lynn Richardson, I would like to acknowledge the presence of Congressman Walter Fauntroy. Congressman Fauntroy will not be rejoining the Congress or the committee next year because he forfeited his seat when he sought higher office in order to provide some much needed leadership in the District of Columbia, and even though he did not succeed in that political endeavor, I am confident that the work that has to be done will continue to find Walter Fauntroy in the forefront, as he was in the civil rights struggles side by side with the late Dr. Martin Luther King. You were one of the original founders of the Congressional Black Caucus and you will really be missed next year but we don't expect that you will be far away from your Congress, your Caucus, and the work that this Select Committee has been able to do as a result of your support and participation.

Mr. FAUNTROY. I certainly want to thank the Chairman for that very kind recognition of my presence at this most critical hearing.

As one who has represented the District in which these problems and related problems are reflected most acutely in this Nation, I am certainly interested in the subject matter today and look forward to continuing my association with my colleagues on this committee in addressing these and a number of other related problems that afflict our Nation.

Mr. RANGEL. Thank you, Walter.

Dr. Richardson.

STATEMENT OF DR. LYNN RICHARDSON

Dr. RICHARDSON. Thank you, Mr. Chairman. I am Dr. Lynn Richardson, Associate Chief of Emergency Services at Harlem Hospital Center. I am pleased to appear here today representing the American College of Emergency Physicians to discuss the emergency department overcrowding crisis.

The American College of Emergency Physicians is a medical specialty society representing more than 14,000 emergency physicians across this country. I am accompanied today by Stephanie Kennan of our legislative staff.

Emergency departments are designed for the rapid evaluation of the acutely ill and injured. Emergency department overcrowding is what happens when there are no facilities available for patients who have been examined and evaluated and have been found to need further care.

When an emergency department becomes crowded with patients who require admission to the hospital, the availability of quality emergency care to each individual arriving in that department is jeopardized.

Let me try to explain to you what I see in my emergency department. I walk into my emergency department at 8 o'clock one morning, and I immediately notice Mrs. Johnson, a 49-year-old woman who finally came to the hospital after experiencing several days of chest pain.

She has been given medication to control her pain, and we are continuously monitoring her heart rhythm. The reason I notice her immediately is because she was here when I left yesterday. This

woman has spent the last 23 hours in my emergency department. She should be in a bed upstairs in a quiet room in the hospital, but there is no room upstairs, so she has been watching the respirator attached to the woman across from her who is lying in coma from a massive stroke.

She has had her stretcher pushed to one side when the young cocaine addict next to her has a convulsion. Their stretchers are so close together that the staff must move Mrs. Johnson to attend to the addict. She has been listening to the teenage girl on the other side of her who took an overdose of pills and has been vomiting and retching into a basin for the last hour.

Twenty-three hours in the emergency department surrounded by these kinds of sights and sounds is not what Mr. Johnson needed or deserved. On this particular morning there are 13 patients like Mrs. Johnson in my emergency department. They need admission to the hospital, but instead are lying on stretchers not meant to be used as beds in an area that is always busy, always noisy, always brightly lit, and the emergency department amenities like hot meals, telephones, and privacy do not exist.

This is not the setting that patients need to recover, and the emergency department is not designed to provide the ongoing care that critically ill or injured patients require. At my hospital we have had as many as 25 patients holding in the emergency department.

We have had patients who spent as much as 5 days in our emergency department, and the time that E.D. staff expenses caring for these admitted patients compromises their ability to rapidly assess and treat the new patients who continue to arrive.

Overcrowding is not just an urban problem. In 1989 the American College of Emergency Physicians conducted a survey of its 54-chapters to help assess the extent of E.D. overcrowding which had initially been reported in New York, Boston, and Los Angeles.

Our chapter survey showed 41 States reporting overcrowding problems. Now, a variety of factors contribute to this crisis. No one predicted the crushing burden that the epidemics of drug abuse, violence, and AIDS would place on our hospitals, and these problems, coupled with a shortage of nurses, emergency physicians, appropriate inpatient resources, and State and Federal funding cutbacks threaten to overwhelm our fragile health care system.

While overcrowding is not caused by the drug epidemic alone, in my community drug abuse is one of the major causes of morbidity and mortality. Many of the patients I treat whose problems are causally related to the drug epidemic are overlooked by all of the current data collection methodologies.

Their diagnosis does not seem to be specifically related to drugs. For example, the elderly woman I treat for a hip fracture because she was pushed down in a robbery attempt by junkies is a victim of drug abuse.

Statistics are collected on the number of IV drug abusers who are brought in for overdoses, but when they are visitors for the kidney disease caused by their heroin or the cardiac or pneumonia caused by the intravenous drug use, those E.D. visits are not counted as drug-related.

IV drug abuse is the major source of HIV infection in my community. Not only does this mean that most of the IV drug abusers in the community have AIDS, but that their sexual partners, even if they do not use drugs, also develop AIDS, and sadly many of the AIDS patients use the E.D. as their primary source of care.

Of course, as crack has replaced heroin as the drug of choice, it has created an epidemic of violence that has ravaged our youth and taxing our emergency departments to the limit. Still, even solving the drug abuse problem would not solve the E.D. overcrowding crisis. There are increasing numbers of patients who come to the E.D. late in the course of their illnesses, not having previously seen a physician.

They lack primary care services because they are uninsured or underinsured. It is important to note that emergency departments are the only entities mandated by Federal law to provide care to call who need it, regardless of their ability to pay.

Thus, the American college of emergency physicists supports amending the Medicaid law to establish presumptive eligibility for unsponsored patients who present to the emergency department with emergencies, increased payment for physical evaluation and management services under Medicare and Medicaid, which are currently undervalued, and increased appropriations for health education for emergency medicine training programs and undergraduate nursing education.

In addition, the American College of Emergency Physicians is a member of the Physicians Access to Care Coalition, which is comprised of over 21 physician organizations working to urge Congress to adopt legislation providing health coverage for all Americans.

The coalition preserves the approach which builds upon the strength of the public-private insurance system and includes employer mandates and Medicaid expansion. The American College of Emergency Physicians realizes that in these times of severe budget deficits hard choices have to be made and simply telling you to spend more money is not very productive.

However, as a physician I can only speak to the problems facing me as I try to care for all of those who come to my emergency department. We must guarantee that the emergency department will be there to provide emergency medical care to all those who require it. Overcrowding jeopardizes our ability to provide that care promptly to each of us, regardless of where we live and regardless of our ability to pay.

Mr. Chairman, we again thank you for the attention you have focused on the problem of emergency department overcrowding, and we look forward to working with you on solutions to the problem.

[The statement of Dr. Richardson appears on p. 70.]

Mr. RANGEL. Thank you, Dr. Richardson.

I was talking with some of my colleagues about the presumption of Medicaid coverage that you have mentioned. We would presume that in providing emergency care that you would believe that if the person did not have private coverage that they would have Medicaid coverage.

Could you amplify on that problem so that we can try to correct it?

Dr. RICHARDSON. Well, there is this tremendous gap, this huge group of people who are called the working poor who are not poor enough to currently apply for Medicaid which, as you know——

Mr. RANGEL. Well, how would the presumption help you? You mean that you would at least get reimbursed for the emergency service——

Dr. RICHARDSON. That is correct, that at least for those services which truly are emergency in nature, everyone has to have some sort of coverage, even if they do not qualify under the current Medicaid eligibility requirements.

Mr. RANGEL. Now, let me ask this, you at Harlem Hospital enjoy an affiliation contract with Colombia University.

Dr. RICHARDSON. Yes; we do, Mr. Chairman.

Mr. RANGEL. That would mean that the professional health services are provided by contract to the city and to Harlem Hospital.

Dr. RICHARDSON. That is correct.

Mr. RANGEL. Now, as it relates to the academic needs of providing health care, that is providing the people to be of support to the doctors and nurses, since we are dealing with a university system, why would not the educational part of Colombia want to make certain that there is no shortage of nurses and support of health care providers for the doctors and the graduates of their prestigious medical school?

Dr. RICHARDSON. Well, I certainly wouldn't presume to speak on behalf of the university, but I will say that the problem particularly of the nursing shortage is one which every hospital, university and voluntary and public alike is facing. This is not a simple problem, and it is not going to be solved by any single institution, whatever efforts they may be making.

Mr. RANGEL. Well, let me tell you, Doctor, one of the reasons why I was attracted to the discussions that we had is because you made it clear to me that we weren't just talking about my home town hospital.

Dr. RICHARDSON. That's correct.

Mr. RANGEL. It would seem to me that the American College of Emergency Physicians should realize that the prestige of their profession would be at stake when they are being asked to provide services that appear to be less than that of the minimum standard that should be offered.

Dr. RICHARDSON. Mr. Chairman, that is why I am here.

Mr. RANGEL. We lawyers are guilty sometimes of going into court allegedly providing constitutional protection for defendants, when a clear look at what is going on in our courtrooms would indicate that those defendants are without counsel because of the workloads that are on public defenders.

I am not prepared to get involved in the quality of care that is reduced by the burdens that are placed on our doctors, not at this public hearing in any event. But it would seem to me that the College of Emergency Physicians will be insisting, not that Columbia assumes the burden for the entire Nation, but that no teaching school allows its doctors to go into that situation without being certain about the prestige of that university and the political influence, I might add, I would want the record to state that Columbia University is in my congressional district and receives more than

its fair share of Federal funds in terms of research because of the expertise that they are able to produce for the scientific world.

So I would expect that they would be providing the leadership at my little hospital in saying that if there is a need for more funds to provide the nurses, let Columbia lead the way in showing other universities the contributions that they can make following Columbia's lead.

Now, I am not helping the College of Emergency Physicians for you. I am doing this for myself. I just expect that the physicians would want to do these things in order to enhance their profession. I would like to conclude by saying that what Congressman Oxley has pointed out in his opening statement was the same thing that—who is the other doctor that was with you when you visited with me?

Dr. RICHARDSON. Dr. Steven Lynn or Dr. Mark Henry? Those were the two.

Mr. RANGEL. Well, one of the other doctors, is that when drug abusers are receiving more than their share of the attention in the emergency rooms, it reduces the attention that you can give to other people, and this hearing also wants to point out who those executives are. They are chief executive officers, they are mayors of cities, they are Bishops and Cardinals and people who have coverage and who are affluent, but still, that trauma center was not designed to take care of the problems of the poor.

It was designed to take care of emergency situations, and a lot of people who believe this is just our problem or inner city problems would find that the hospitals located outside of the so-called problem area will not be able to give them the type of services that they should expect, and Harlem Hospital does an outstanding job with limited resources, and I only mention my friends at Columbia so that you, coming from the flag ship of public hospitals in the city of New York, would be able to tell the President, Mike Sofran, the deep respect I have for his leadership, and the fact that we would not want to be disappointed as a doctor at Harlem Hospital and the Congressman representing that District when we have laid all of this on the public record for their positive response.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Both of you have suggested that one of the major problems of public hospitals and emergency rooms is the inability to find a bed in the hospital, to get people out of the emergency room, yet there is some conception out there nationwide that we have an excess of hospital beds.

Are you distinguishing between beds in public hospitals and beds otherwise available?

Dr. KELLERMANN. The basic issue is one of distribution. There are a number of rural hospitals that are perhaps over-bedded or not supported; even in some cities a number of hospitals will have significant vacancy rates while others are severely overcrowded.

If you took the whole set of beds in the United States overall, we look over-bedded, but in fact, in many communities—even a number of smaller cities and small towns—one or two or three or four hospitals will be heavily overused. All hospitals are not alike.

Since we have appropriately begun to focus particular services in given institutions in a community, it is no longer simply a matter of shuffling patients from hospital A to hospital B simply to correct a distribution problem. Another issue is that many of the beds that we are counting today aren't staffed beds. They are not really available for patient care. In Memphis, a number of our major private hospitals have critical care units that are shut down. Their equipment, monitors, and beds—all of the physical plant amenities—are there, and they are kept on the books as hospital beds—but they are not staffed. In these same hospitals critical care patients are being held in the emergency department for extended periods of time. It really is a distribution issue and a staffing issue. The costs are there, regardless.

Mr. COUGHLIN. The traditional role of the emergency room has been to provide critical care to seriously injured patients immediately in the minutes and hours after their injury. It is my understanding that emergency room staff now spend considerable amounts of time treating conditions that are not critical in nature.

Would you agree with that, and to what extent is the severity of the condition taken into account when decisions are made as to who should be the first to receive treatment?

Dr. RICHARDSON. Well, it is certainly true that increasing numbers of patients are turning to the emergency departments as their only access to the health care system for some of the reasons we have already mentioned, but perhaps more insidious than that is the fact that—and clearly, those people could be cared for in less expensive settings if those services were available in the community, but more insidious than that are the people we see who do come to the hospital with genuine emergencies which could have been prevented had they had access to primary care earlier on, so to assess the impact of the lack of primary care services on the emergency department overcrowding crisis is not just to look at the patients who present with nonemergencies, which I would guess varies from perhaps 10 to 30 percent, depending on where you practice, but the real tragedy are the people who come with real emergencies which could have been prevented if they had been getting regular or primary care.

Dr. KELLERMANN. Use of emergency departments for nonemergency problems does occur, there is no question about that. It does tend to crowd waiting rooms, but it is really not the cause of emergency department overcrowding. E.D. overcrowding occurs because we don't have enough staffed inpatient beds—critical care and medical-surgical beds—to move the stabilized E.D. patient upstairs. There are two very different phenomena.

I don't like to have a crowded waiting room and patients don't want to wait 5 hours to be seen for a sore throat, but I am not too worried about that. I am far more worried about the heart attack victim or the stroke victim or the gunshot wound victim that we have to continue to keep on a ventilator or watch in our E.D. when we really need to be focusing on new patients as they come through the door.

Mr. COUGHLIN. Finally, just a brief question on something that is of concern to this committee, particularly concerning our jurisdiction. The Drug Abuse Warning Network [DAWN] release earlier

this month showed a continuing downward trend in cocaine and heroin emergency room mentions for the first quarter of 1990. That seems to confirm the fourth-quarter 1989 decline. To what extent, in your judgment, is there any genuine national trend out there of decreased drug use that you are seeing, or is this an aberration?

Dr. RICHARDSON. I am unable to provide any support for the DAWN data based on my recent experience in my emergency department.

Dr. KELLERMANN. Most of the DAWN data that is normally interpreted involves the entire system. My understanding of these recent statistics were drawn out of a relatively small number of surveillance hospitals. As I think both Dr. Richardson and I said earlier, the problem with DAWN data or data from any emergency department surveillance system is they depend on revenues of charts. They—the reviewers—are looking at a chart for some reference or mention of drugs in the case.

Often, although I hate to admit it, trauma center and emergency physicians deal and document with the most evident problem. We don't necessarily put on the chart that drugs were a factor in this person getting shot or stabbed or in that person's endocardites or cellulitis. As a result, I think there is a huge number of drug-related emergencies—obstetric, trauma, and medical—where cocaine or other drugs aren't explicitly noted on the chart and, therefore, aren't even picked up on the DAWN surveillance system. That is a problem with any emergency department-based surveillance system.

For example, one injury surveillance system in a large city on the east coast recently looked at all of their trauma admissions and found out that drugs or alcohol were documented on only 3 percent of those charts. You and I know that far more cases than that involve drugs or alcohol. It simply illustrates the limitations of the monitoring system.

Mr. COUGHLIN. How about the number of OD cases that are coming in?

Dr. KELLERMANN. I haven't seen a substantial decline in the number of OD cases at my hospital. That is all I can speak to.

Dr. RICHARDSON. Neither have I.

Mr. COUGHLIN. Your figure of 38 percent of the expectant mothers coming in to your regional center, testing positive for cocaine and drugs, is just staggering. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Oxley.

Mr. OXLEY. Thank you, Mr. Chairman.

Let me follow up and ask both of you, what are the obligations under State law or perhaps local ordinance for treating an OD patient? What obligation do you have to report or divert that individual either to a law enforcement system or to long-term drug treatment?

What are your obligations?

Dr. RICHARDSON. The legal obligations?

Mr. OXLEY. Yes.

Dr. RICHARDSON. In New York State, none that I am aware of.

Mr. OXLEY. So that if someone comes in——

Dr. RICHARDSON. Clearly, I think the physician has some moral obligations to try to provide the patient with the services that will

address their problem by referring them to some sort of long-term drug care program.

Mr. OXLEY. But nothing in terms of law enforcement?

Dr. RICHARDSON. No.

Mr. OXLEY. What has been your experience, Dr. Richardson, in terms of ODs? Does the OD patient come in, get treated in the emergency room, and then essentially released back to this habit, only to return some other evening during that week?

Dr. RICHARDSON. Certainly, it is true that we have sort of a stable, you know, set of customers who do return over and over again with problems related to their drug addiction. There is just no question about that. Part of my frustration is that even if we are able to prevail upon an individual to seek treatment for their drug addiction, the available services have so been reduced that it is very difficult to immediately, you know, to seize the moment when, because of their emergency, they are faced with the danger to themselves that their addiction creates, and to take that opportunity to get them into a treatment program.

There are waiting lists of weeks to months in many of the programs in the city, and probably we have more resources than many other communities regarding drug treatment.

Mr. OXLEY. I know the chairman has pointed that out, particularly in New York, and I am sure that is true in other urban areas. However, should that situation ease and should that individual be able to be diverted to a treatment center, what percentage of those people would take advantage of treatment?

Dr. RICHARDSON. Well, I can tell you that if the services are unavailable, none of them can. You know, drug treatment is a very, very difficult problem to treat long-term. The medical treatment of it long-term is difficult, and I am not going to try to mislead you with nonrealistic rates of our success.

I think the answers to the drug abuse problem are complex. The drug problem is a symptom of many, many other things that have happened in that person's life, and until we are addressing, as a society, all of those issues, I think the success of drug treatment alone is limited, but it has to be a starting point, and even that is not available.

Mr. OXLEY. But those people are essentially breaking the laws of the State of New York when they consume drugs; is that not correct?

Dr. RICHARDSON. More than that, they are killing themselves.

Mr. OXLEY. But I am trying to get the point across that at some point, there ought to be some type of intervention, whether it be in the legal system or a diversion to some kind of treatment. Otherwise, as you indicated, you have a fairly steady clientele.

Yes, Dr. Kellermann?

Dr. KELLERMANN. It may seem to be a fine legal point, but basically if an individual comes to my emergency department with a large quantity of cocaine in his pocket, he will certainly enter the legal system in a rapid manner. If he presents with a large quantity of cocaine in his blood stream as a medical emergency, we deal with the medical problems first and absent any substance in an external location, there are no laws that provide for a change of possession if the possession is in the patient's blood stream.

We do our very best to work with that person and encourage them to get into drug treatment. As has been said, the waiting lists are so long that it effectively precludes most of these people maintaining the commitment long enough to get into treatment.

Many of the others have no interest in it. It has been my experience that if the individual doesn't want to stop, doesn't have some motivation to do so, trying to mandate them to go into a program is an exercise in futility. It is a very, very frustrating issue.

If we are to somehow criminalize seeking medical care, though, and tell these overdose patients, if you come into an emergency department, a call will be made to the police officer, and you will be arrested, even if you have nothing in your possession, my fear is that these people would end up dying on the street corner rather than getting the care that they need, and at least some opportunity for crisis intervention in the E.D.

I wish that there was a cleaner, more straightforward way to deal with it, but I am not sure that there is.

Mr. OXLEY. Do you have the same essential clientele that Dr. Richardson has that you see more than once?

Dr. KELLERMANN. Well, there is no question that there is a hard-core group of users that repeats, just as there are a hard-core group of alcohol-related patients or seizure patients that we see over and over.

One thing that strikes me, and you all are more aware of this than most in the country, is how pervasive drugs are in a number of areas of the society. There are a lot of folks out there who think cocaine and drug problems are limited to lower classes or certain minority populations.

Even in my public hospital I see a lot of working people, middle-class people, and occasionally a rare upper-class person who got sideways in a car crash and comes in overdosed. It is not a problem that is limited to a particular segment of the population. It is something all of us have to confront and deal with.

Dr. RICHARDSON. I think that bears repeating, particularly with the explosion of cocaine, you know, the diversity and pervasiveness of these problems is just astounding.

Mr. OXLEY. That was my next question, and that was particularly with crack, have you noticed a significant increase in traffic in the emergency room since the crack epidemic? Has that been the critical factor here, Dr. Richardson?

Dr. RICHARDSON. Certainly, the current drug of choice in my community is crack, and it certainly does seem to have a much more general appeal than the former drug of choice, which was IV heroin. You had to have a certain commitment to destroying yourself to be able to, you know, stick a needle into your arm, whereas crack is so much more easily available, and as I say, attractive to a much larger group, that it seems to really have established quite a dedicated following, unfortunately.

Mr. OXLEY. What has been your observation of the effect on the individual of crack, say, versus heroin?

Dr. RICHARDSON. Well, of course, the physiology of the drugs are totally different, and part of the problem is that crack seems to eliminate impulse control, and I think this is directly related to the

explosion in violence we have seen, not only as part of the business of selling cocaine, but in the users themselves.

This is a very different group. They come in wildly agitated and combative, very different from the somnambulant condition of the heroin addict 10 years ago. I think that is directly related to the visibility of this problem now, because of the behavior of the addicts.

Mr. OXLEY. Dr. Kellermann, do you concur in that?

Dr. KELLERMANN. We saw a major spurt in drug-related emergencies with the advent of crack in Memphis. We did not have an enormous drug problem prior to that time. I think the numbers have tended to plateau rather than continue to climb, and if we are making progress at any level, I think we are making progress in the general perception among people in the community that cocaine is a danger and not a safe recreational drug. That is a major mind-shift in the last 5 or 8 years.

Now, unfortunately, that hasn't made a dent with the people who are currently doing it. There are a lot of people out there who are still buying the idea that, hey, you can handle this every once in a while for fun. I think that if we can somehow get the message across to kids and to other people that currently look up to drug dealers as economically successful people with status, to see them instead as predators in the very neighborhoods that they are working in, that will help as well.

I am not sure we have gotten that message across yet. There are too many kids wearing cardboard beepers on their belts because their role models for success wear real beepers on their belts. We need to somehow get the mind-set across to the next generation that drug dealers are predators that are feeding off of their own neighborhoods, their families, and the people that they care for. They are not individuals to emulate.

Mr. OXLEY. Thank you very much.

Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. I would like to again thank Dr. Kellermann and Dr. Richardson for being here. I know you both have your own hospitals and you represent national organizations as well.

I would like to first be clear as to the percent. This is a hearing on emergency room crisis, the impact of drug abuse, the percent that come to you because of an overdose, and illness as it relates to drug overdose or drug use, rather, and those who come in because of the violence of the street-fighting and so on.

Dr. RICHARDSON. Well, I think part of what we have been describing is the problem in really getting a handle on those numbers, although I think it is very clear that any estimate I have ever read or heard quoted underestimates the problem.

Mr. SHAYS. I don't mean the number versus nondrug-related activities. I mean, just take those two issues and just give me the percent.

Dr. RICHARDSON. And comparing them.

Mr. SHAYS. In other words, is the biggest problem injury on the street or is the biggest problem drug use, and the person who has been taking drugs?

Dr. KELLERMANN. I think to give you a guesstimate, which is the best that anybody is going to be able to do at this point, absent a very sophisticated and determined effort at surveillance at a number of hospitals, I would say that probably overt, explicit overdose cases, the "mentions" that you get with DAWN are probably 10 to 15 percent of the drug-related emergencies.

You have got a larger group out there that are less clearly documented, that are injured individuals, obstetric-related complications, medical and psychiatric complications of chronic drug abuse and other types of emergencies, but where you draw that line and say that it is "drug-related" or "not drug-related" is very hard to define. That is why those figures are so soft.

Mr. SHAYS. This is just the first part of a few questions I want to ask. I don't want to spend much more time. I am really just trying to get a handle, though, on whether you have scores of people coming in because of stab wounds or gunshot wounds that are drug-related or are they related to a whole host of other things as well?

Dr. RICHARDSON. Well, I am sure that everyone is aware that the media in New York City has discovered a phenomenon that, unfortunately, emergency physicians were familiar with for sometime before the media picked it up of these innocent bystanders caught in the crossfire.

I think certainly there is something to the point that the violence can affect even people who are not using the drugs, and I think that is why that has permitted so much attention, but, yes, I mean, certainly a great deal of the trauma which we are seeing now is related to either the business of dealing drugs, that is, drug dealers shooting each other, or innocent bystanders who get caught in the crossfire while drug dealers are trying to shoot each other, or victims of addicts who were committing crimes to get money for drugs.

Mr. SHAYS. We are going to have a vote in just a second. I would like to ask just a few more questions. We have 36 million Americans who have no insurance, we have about 30 million who are underinsured. In both cases, the hospitals absorb the cost when they treat patients like that.

Dr. Kellermann, you were suggesting that there be a basic level of service for—you said to provide a basic level of health insurance for all citizens. I am assuming that you mean we would, in essence, have national health care insurance, but it wouldn't be for all types of health needs.

It would be just for the basic health care needs. Would that include emergency of health care needs?

Dr. KELLERMANN. I think all of us are going to have to grapple with this problem in a fundamental way in the next 2 to 5 years. We kind of keep whittling at it and hoping it is going to go away, and a number of organizations are presenting somewhat competing plans.

Personally, and I am only speaking for myself, I think we need to look at a fundamental, basic health care system for this country. The American College of Physicians has supported that approach.

Mr. SHAYS. Right, but my understanding is that when I see the words "basic level," in other words, rather than giving a whole

range of health care services that would be provided in national insurance, it would be just the real basic acute need.

Dr. KELLERMANN. I think we will miss the boat if we focus only on acute care. Even as an emergency physician, I think that if there is any single thing we need, it is preventive services, injury prevention and illness prevention. These must be part of any basic health care.

Example: When we are short maternal and child health and pour billions of dollars into neonatal, intensive care units, that is a terribly costly way of dealing with the problem of infant mortality in this country. Any system must be comprehensive in its scope, but I don't think that, as a society, we are going to be able to afford a heart or liver transplant for every patient in every circumstance.

Mr. SHAYS. I hear you.

Dr. Richardson, let me ask you this: You seem to imply something different that I haven't thought of, and most people have maybe thought. What I thought I heard you saying was that you would presume that a patient was eligible for Medicare.

I was just wondering if you were then suggesting that we would give all Americans emergency health care services. Maybe I misunderstood you, but it seems like an interesting idea.

Dr. RICHARDSON. I would be happy to give some more detailed information on that particular legislative issue, which is an item that we are working on.

Mr. SCHEUER. But is that what you were suggesting?

Dr. RICHARDSON. That is part of it, yes.

Mr. SCHEUER. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Grant.

Mr. GRANT. Just briefly, Mr. Chairman, if I could ask one follow-up question because Mr. Shays and I were apparently thinking along the same line to state the obvious maybe you should tell the committee, then, who pays for the extra costs of running your emergency rooms and trauma centers if the patient didn't have Medicaid coverage?

Dr. RICHARDSON. Well, in my particular case it is the Health and Hospital Corporation and ultimately the city of New York, because I work in a public hospital.

Mr. GRANT. Dr. Kellermann, is that the instance?

Dr. KELLERMANN. Shelby County gives us an operating subsidy each year. The hospital eats an awful lot of the cost. We get a certain amount of supplemental Medicaid payments from the State of Tennessee out of recognition of the tremendous amount of uncompensated care we give.

Basically, the hospital, through hook or by crook, survives, though it must eat the costs for a lot of the care we provide.

Mr. GRANT. Is it fair to say that the patients who pay privately pay their share of these costs because they are billed for the cost of the hospital as a whole?

Dr. KELLERMANN. Even Reinhart of Princeton has called cost shifting the fig leaf of American health care. That is what has kept the system going for all these years. It has been essentially a sick tax as a lot of people have called it. That is getting harder and harder to do. We have got to realize that hospitals, public and private, are now having to negotiate preferred provider agreements

and contracts. Third party payers are getting tired of cost shifting, but that has been the only way we have been able to keep many hospitals operating. If you cut out hospital cost shifting and provide no source of revenue to take its place, we will not be able to keep the lights and the water running, and we will not be able to continue to deliver care.

Mr. GRANT. You are a taxing authority without being elected, then, in any sense, those hospitals are?

Dr. KELLERMANN. You have either got to get the money to pay for your staff and pay for your medications and to pay for your services, or you close. If you can't get the money one way, you have got to try to get the money another way. It is getting harder and harder to do.

Mr. GRANT. So all of us pay the cost?

Dr. KELLERMANN. We all pay one way or another. It is just a matter of whether that is done fairly across the board or whether it is focused on a group that really didn't have a say in it.

Mr. GRANT. Thank you.

Thank you, Congressman.

Mr. Chairman?

Mr. RANGEL. Congressman Fauntroy has yielded to Mr. Guarini.

Mr. GUARINI. Thank you, Mr. Fauntroy.

I want to thank you, Dr. Kellermann and Dr. Richardson for the deep commitment each of you have and for your being here and testifying. I am sorry I wasn't able to hear the beginning. I was at a budget conference.

I would just like to ask, of all the public hospitals that we have in our country, Dr. Kellermann, how many people are turned away? What amount of people are turned away if they don't have any kind of coverage or don't comply with Medicaid?

Dr. KELLERMANN. In public hospitals?

Mr. GUARINI. We know approximately 36 million people who have no coverage whatsoever. Would a public hospital turn away from an emergency room someone who is an addict or someone who is reported in as a drug-related crime?

Dr. KELLERMANN. Let me speak for my institution. I think I can speak for all members of the National Association of Public Hospitals. While we are, in fact, subsidized in part by the Shelby County government our primary role is to provide care to Shelby County citizens. We turn no one away regardless of their county of origin, their social background, their politeness or lack of politeness or any circumstance. If they need care and they need emergency treatment, they get it. We turn nobody away.

Mr. GUARINI. Now, is that true about all public hospitals or are there policies they have amongst a board of directors?

Dr. KELLERMANN. I am unaware of any public hospital that denies care to a patient in need, particularly if that patient presents with an emergency problem.

Dr. RICHARDSON. That is the essence of public hospitals, and in New York State that is true of all emergency departments. We turn no one away, and that is why we are in this crisis.

We can't close the doors.

Dr. KELLERMANN. I would dare say that this type of commitment, in fact, is why a lot of emergency physicians and nurses like Dr. Richardson and myself work in these hospitals.

Mr. GUARINI. Now, being an expert in the field, my question is, in private hospitals is the policy completely in reverse?

I know you are not speaking for private hospitals, but from your knowledge of the field that you are in, what percentage of the hospitals, as a matter of policy turn the patient away if it is a drug-related crime?

Dr. KELLERMANN. I have had a certain amount of involvement with the patient-dumping issue over the last 5 to 7 years, and, in fact, testified on Capitol Hill a few years ago on patient dumping. I think there has been a major shift within private institutions regarding emergency treatment. That has grown out of recognition of Congress' role in fashioning the COBRA legislation and out of the realization that it is a dangerous or harmful thing to dump patients. It is much less of a problem, but I can't say that it is no longer a problem. It is very difficult to pin down, though, when somebody is denied care and when somebody is simply steered to other facilities or another institution. I don't think you could find an institution in the country that has a written policy that they deny care to a particular segment of patients.

Mr. GUARINI. So if someone comes in with drug addiction and wants help, would you say that in an emergency room of almost any hospital in the country that they can get help?

Dr. KELLERMANN. They will get an initial screening evaluation. They will also get, to one degree or another immediate stabilizing treatment.

Mr. GUARINI. Even in private hospitals?

Dr. KELLERMANN. Even in private hospitals. I think our colleagues that practice emergency medicine in private hospitals have always advocated and supported that position, even if we were not getting a great deal of support from their hospital administrators. Now, saying that, I think a number of those patients then will be encouraged to accept transfer or to seek care at another institution rather than ongoing inpatient care. Just as an example, 2 nights ago I saw a young man with hepatitis which may or may not have been due to drug abuse, who was badly dehydrated and badly jaundiced. He was initially seen at a private hospital where he was screened, evaluated, given intravenous fluids, and told he needed acute care hospitalization. When it was determined that he was uninsured, they came back to him and said, "We need a $3,000 deposit." When he stated that he didn't have the money, they told him "You have enough IV fluids in you; take a little medicine for nausea and if you don't feel better in the morning, go to the regional medical center at Memphis." That is what he did, and we immediately admitted him to the hospital.

Mr. GUARINI. What is the policy in hospitals if a person comes in, you suspect that they are drug related—not only to their injury, but they are an addict, and they resist any kind of testing whatsoever, but you know from your examination medically that this is a very suspicious case, do you have a right to violate his right of privacy or do you just treat him for his broken leg and then send him away?

Dr. KELLERMANN. The issue depends on the person's level of intoxication. If they are impaired by the drug or by alcohol to a degree that they lack sufficient insight to make a competent decision about their own welfare, then we manage their emergency problem with or without their consent. I would rather be faulted for doing too much than not enough.

If the individual is an active drug user, has track marks up their arms, smokes crack three times a day but is clear and says "I don't want drug treatment, I don't want any medication, I want this, I want that, I want to be released." We cannot force that person to accept drug treatment or any other medical treatment. It is a tough call to make sometimes, but the issue revolves around the person's competency. If they are competent, they are entitled to make an incredibly stupid decision, and we can't rule against that. If they are incompetent, our basic principle is to provide needed emergency or life-saving treatment and worry about the niceties later.

Mr. GUARINI. There are policy procedures set down or is this just left from doctor to doctor who is handling the emergency room at the time? Do hospitals have a firm policy on this?

Dr. RICHARDSON. Well, there is a firm policy but there is a judgment that has to be made by the physicians as to whether or not this person is capable of giving informed consent or alternatively receiving treatment.

Mr. GUARINI. If he resists, you don't touch him?

Dr. RICHARDSON. This is America, a free country, and they have a right to refuse.

Dr. KELLERMANN. If a cocaine addict came into my emergency department with a heart rate of 180, and severe chest pains and was confused and combative and said "leave me alone, I don't care," I would put that patient in restraints, start an IV, give him medication to cool off his heart, and if necessary put him in the intensive care unit. If he woke up the next day and was now alert, knew where he was, what day it was, what time it was, why he was there, and said "I want out," I would have to let him pull out his IV, take off the restraints and walk out of the hospital. That happens all the time.

Dr. RICHARDSON. Yes; it does.

Mr. GUARINI. You have to be sure you are right, otherwise malpractice would be tremendous.

Dr. RICHARDSON. I actually think, as Dr. Kellermann said, these are relatively easy decisions because I would much rather be sued for restraining a patient against their will than letting one who is incompetent out the door and they do harm to themselves or others.

Mr. GUARINI. Thank you very much, Doctors.

Mr. RANGEL. The Chair will turn this over to Congressman Fauntroy. Two things are happening. One, we have a vote on the floor, and the second thing is that I and Larry Coughlin will have to have a private meeting with the President of Colombia who is now with the Speaker of the House. Let me thank you two for the testimony that you have given today plus the leadership that you are providing.

You can see that we do have an interest in the Congress, and I will be reaching out to your representative organizations to see whether or not we can have a short conference to get you a list of things that can alleviate the problem that you have and to see whether we can get—instead of just talking about the cost of additional moneys for emergency rooms or hospitals—some responsible research to prove that you are really reducing the costs of health care by preventing people from having to need the type of expensive services that hospitals and especially emergency wards give. So for instance, they can start doing that, remembering that we will have to bring in, perhaps scratching and screaming, the American Medical Association, but after all they do have some responsibility to help us to get some sane health policy in the Congress. Now, we, Dr. Richardson, are fortunate because in our congressional district we are already starting to try put those things together with City College, with Columbia, with Harlem Hospital, with private sector hospitals, with the New York Hospital Association, and also with the Health and Hospital Corporation because we do have an easier work relationship with these agencies that are working together. We are supposed to get our Harlem Nursing School once again, and I hope perhaps that could be the anchor for our chancellor bringing in those other type of professionals who are so necessary, so we are moving in that direction.

I met yesterday with the new chancellor of the city university. She wants to get involved in doing that type of thing.

Perhaps if we can get the national leadership to show the Congress in the dollars and cents way where we are really doing the right thing, I am sure we can get their attention a lot easier than just by talking about standing entitlements. So you two have made a major contribution.

Jim Scheuer is back and Congressman Fauntroy is here, and I will see you back home.

Dr. Kellermann, I will be in touch with your organization.

Dr. RICHARDSON. Thank you, Congressman, very much.

Mr. RANGEL. Is Larry Cates still with the public hospital?

Dr. KELLERMANN. Yes, sir; thank you, Mr. Chairman, for your interest and commitment, and that of your committee.

Mr. FAUNTROY [presiding]. Let me say to our very distinguished witnesses how much we appreciate the unique blend of your experience in your professional responsibilities at hospitals and your ability to represent the views of national associations on these matters. I wanted to assure you first of all that the sudden absence of the Members here was not because they were weary of your testimony, it was because each of them had to represent their constituents on the floor of the House with a vote on the journal.

You will notice that I very kindly consented to yield my period in the questioning to Mr. Guarini, who has the privilege of representing his constituents on matters like this. That is because I represent more people who pay taxes than any single Member of this panel, any single Member of the House, and yet I do not have the privilege of voting on the floor.

I vote in committee, and I have seniority, and I am chairing this meeting at this point. However, I make that point because I have three questions of you pursuant to your testimony that flow from

my experience with my constituency. That experience is one in which the people who live in my district have reflected in their experience most acutely the problems that you have addressed.

Obviously, you have severe problems in Harlem and in Memphis, but nowhere are the problems you have addressed more acute than in the District of Columbia. We have the highest drug driven violence rate in the Nation, we have the highest infant mortality rate in the Nation, we have the highest AIDS rate in the Nation, we have the highest percentage of female headed households in the Nation, and that is not unreasonable when you recognize that we have 80 percent of the region's poor living in this jurisdiction and must provide 70 to 80 percent of the public services for that group. That being the case, I am interested in three things. First, you have indicated the inordinate burden that falls upon public hospitals with relation to the provision of emergency services, emergency services that are, of course, now the result of increased drug use and drug related violence. In the District of Columbia we have had 400 hospital employees at Howard University released and denied employment over the past 3 months because the cost of uncompensated care in its emergency room had drained its resources so badly that it cannot provide the acute care that hospitals are obligated to provide in both the public and private sectors. Accordingly, I want your view on the extent to which we ought to involve all hospitals, public and private, in sharing the cost of uncompensated care through the pooling of uncompensated care resources into one pot to be drawn upon by the Harlem Hospitals of the Nation which carry an inordinate amount of the burden of providing that emergency service.

Dr. RICHARDSON. Well, clearly the burden has fallen disproportionately on public hospitals, but the segment of the population that is uninsured and underinsured has now grown to the point where I am not aware certainly in my area of any hospital that isn't giving a significant amount of care in an uncompensated fashion. Certainly, we should share the burden. Whatever is in the pot should be evenly shared, but I just don't see anyway around it. You are going to have to put some more money in the pot.

Mr. FAUNTROY. Sir?

Dr. KELLERMANN. Tennessee and various States have had formulas as you suggest that spread the cost sharing across institutions. In Tennessee, all the hospitals in the State through registration fees and otherwise contribute to the State's Medicaid program. Medicaid, in turn, pays back disproportionate dollars to hospitals that provide a disproportionate amount of medical care, recognizing that high Medicaid hospitals also carry high levels of self-pay or totally uncompensated care. I think, ultimately, the issue is how wide do we draw the base for support of the programs. Is the base going to include only public hospitals? You and I know that won't work. Is the base going to be the hospital industry overall in order to pickup the privates? That may well be the most practical political answer, at least at this point in time. Should the base be all payors in general, as is the case in a number of Western European nations, Canada and elsewhere? I think that is where we have to respect your insight and that of your fellow Members of Congress

as we as a society decide how do we want to organize our health care system and pay for that system.

I think in general the broadest base that is politically acceptable will be best. We must also take measures to try to get a handle on administrative overhead. Administrative costs are embarrassing in this country relative to those of a lot of other societies. Lower cots for administering these funds will also be part of the answer.

What you are saying may well be the most practical solution on the short- to middle-term, and there is no question we have got to do something right away.

This is not an issue that we can look at a 10 or 20 years before addressing.

Mr. FAUNTROY. In the information provided the Members for this hearing and which is available to you as well, there is an account of a woman who died at our D.C. General Hospital emergency room last week as a result of the hospital emergency room's inability to deal with her situation.

That was the same D.C. General Hospital where we have, at times, in the golden hours 50 percent vacancy rates among the nurses who are there. Uniquely, in the District of Columbia, the nurses who work for our public hospitals are paid less than nurses who work just across the line in suburban Maryland and Virginia. That being the case, we have this pressing spread of the burden in terms of the division of emergency services. That brings up the second question I have. As you mentioned, in addition to the emergency need in some hospitals where emergency needs are highest, the beds in those hospitals are overcrowded. To what extent can we look forward to sharing vacancies in public and private hospitals in a given jurisdiction where the burden of emergency care is not so severe? Just as I say there ought to be uncompensated pooling of resources so that if Harlem Hospital takes a disproportionate amount of the burden of delivering uncompensated care, the other hospitals would contribute in a fashion that Harlem could draw upon. By the same token, what can we do in terms of the prospect of sharing acute care bed space outside of the hospital that you describe to me that is so overcrowded that a person must sit, as you pointed out, among people who are suffering emergency and traumatic situations?

Dr. RICHARDSON. Well, again that is a short term solution and certainly general in New York State has perhaps led the nation in terms of regulation along these lines. When we have patients who are waiting in our emergency department that we don't have room for, we are required to call neighboring hospitals in an attempt to transfer patients to them if they have medical needs. What we have seen happen in our system is that the public hospitals have filled up because of the population they serve. The voluntary hospital, in an effort to contain costs, have cut down on beds to try to become efficient, and so we now are in a situation where not only is Harlem full but St. Lukes Roosevelt is full, Presbyterian is full, New York Hospital is full, and all of the surrounding voluntary hospitals are full, and I think what happened in New York is instructive. It starts in the public hospitals and the hospitals of last resort, and as the problem grows and continues to be addressed, it spreads to the point where it affects an entire community, and so

by short-term what we did was spread all of this burden around, and now it has become too much even for the combined resources of public and private hospitals in the city.

Mr. FAUNTROY. I see.

Dr. KELLERMANN. We periodically transfer a small number of emergency patients to neighboring private hospitals when they have some vacant beds. They are willing to take them if we pay for their care. However, there is not a viable long-term option. As Dr. Richardson has said, and as I emphasized in my testimony earlier, many of our private-counterparts are just about as crowded as we are.

Recall the 3-month interval that I audited emergency room department diversions of ambulances in Memphis. Believe me when a private hospital tells patients "don't come to us," they are really crowded, because that is a major decision. Three of the five private hospitals in Memphis diverted ambulances in the past 3 months, diverted ambulances as often or more often than we did. So this is a problem that really is breaking beyond public hospitals. I think that is important because not only your constituents and my patients, but all of the Members of this committee and all of the Members of Congress need to realize they can't just look at this issue and say, "Well, it is District of Columbia or New York problem or it is a Los Angeles problem. Thank God I don't have to worry about it, I can always get to an emergency department to get treated right away." They may be very sadly disabused of that notion if they come in on an evening and there is not a gurney—a wheeled stretcher—that is vacant in the department for them to lie down on. These days that could happen as easily at many of our best private hospitals as it is in our public institutions. It is in your self interest to be concerned about addressing this issue, it is not just a matter of being a good humanitarian for individuals less fortunate than ourselves.

Dr. RICHARDSON. The emergency department is really the great leveler. When there is no bed, there is no bed for anybody.

Mr. FAUNTROY. I am going to defer my third question until Mr. Scheuer, who has to leave to go to an emergency—though not a medical one—but one dictated by his role as a voting Member of the House of Representatives. I would yield to him for his questions at this point.

Mr. SCHEUER. Thank you very much, Mr. Chairman.

I appreciate your courtesy. I have a couple of questions, but I want to express my appreciation to the witnesses.

Dr. Richardson, I am familiar with Harlem Hospital. I have visited your pediatric wing where I met Maggie Haggerty, the chair of your pediatric department. She represents to me just about the very best there is in health care—brilliant, tough, competent, a lady of tremendous compassion, tremendous feeling for her fellow man. Maggie is a role model for all of us.

Dr. RICHARDSON. Indeed she is.

Mr. SCHEUER. I hope you would express my admiration and affection to her. She was an intern in my office for 6 months about 10 years ago. She got a good taste of the Hill, and today she is performing magnificently at Harlem Hospital. She is a credit to the hospital. Her working down here and learning about governance of

a country, her experience on the Hill and her medical experience has had a sort of symbolic relationship that has enriched her, and through her magnificent service to that community she has enriched us all in return.

Dr. RICHARDSON. Indeed she has.

Mr. SCHEUER. Let me ask you, do you see a concentration of teenagers among the flow of people that come into the emergency services for trauma, for stabbings, for gunshots, as a result of drug wars.

Dr. RICHARDSON. Unfortunately, what we call interpersonal violence or intentional violence is pretty much a disease of the young. The 13- to 25-year-old age group with a predominance of males are most often both the perpetrators and victims of that kind of interpersonal violence. We have seen an especially tragic trend in my community in terms of a decreasing age of the individuals who seem to be involved in that kind of violence.

Really now we are seeing children, not 18- and 19-year-olds, but 13- and 14-year-olds who have already been dragged into the drug culture as runners and dealers, and it is just very, very difficult to watch.

Mr. SCHEUER. Would you say it is an exaggeration for me to say that that flow of younger and younger and younger people into the emergency room as a result of violence and drugs and drug wars, let us say, is a result of our failure to provide them with services that other countries around the world provide their kids, that we provide better off kids, an enriched education, ability to make those young people competent in reading, writing, counting, so that they will succeed in school, ability to provide them health services so that they are healthy and competent, our failure to give these kids child care, our failure to give these young kids the benefit of a Head Start experience, an enriched preschool experience which for many of them, coming from deprived homes, would be their last fair chance to make it in the school system and to become successful? Would you say it is an exaggeration for me to say that much of the blame for the flow of younger and younger and younger kids into the emergency rooms of our nation results from society's failures to give them the facilities and services and caring, from birth on, that produce failure for them?

Dr. RICHARDSON. It is certainly no exaggeration, Mr. Scheuer. I, basically, believe in the fundamental goodness of human beings. I think that a lot of people in the society as general has failed when these young people choose a life where they are at risk for violent death. They have never been given an opportunity to choose other alternatives, and I think we have all failed them in many ways.

Mr. SCHEUER. I agree with you. I think this is a gross example of society's failure to care for its most valuable and precious asset, the youth that constitutes the leadership of the future. To me, a hearing like this where the inundation of the emergency room is produced by this kind of failure, it is almost a biblical morality play, really, right out of the Old Testament where God is telling us, "As a society, you have failed," and God is telling us, "I am going to show you how you have failed." Of the three elements that inundation of people into the emergency rooms, two of them come from failure of society.

The basic purpose of the emergency room is to care for people who have medical emergencies, a heart attack, an automobile accident, all of those things, but then there are two additional flows, one from the drug wars, as you say, these young people who are coming in younger and younger and younger, established, shot, overdosed into the emergency rooms; their failure is our failure.

Their failure is our failure to invest in the facilities and services and benefits and programs that would have made the overwhelming majority of these kids successful, competent, achieving young people in school. A kid that has the benefit of a Head Start education, an enriched pre-school education is twice as likely to finish high school, is twice as likely to go to college, and only half as likely to be on welfare, only half as likely to be a young teenage out-of-wedlock mother, only half as likely to be a young teen male who is engaged in the criminal justice system.

There is the other flow of people, people who use the emergency room as their family doctor due to our failure to provide a national health program that will include everybody, that would include everybody. We are the only developed country in the world that doesn't provide necessary health care programs for all of our people, with the sole exception of South Africa.

Do we want to be South Africa's partner in being the only country in the world that doesn't care for—that doesn't provide minimum health care for all its citizens? It is an outrage.

Therefore, I say that the emergency rooms are a biblical morality play, pointing the finger of guilt at society for having crippled these young people by failure to invest in their health, their education, their well-being, and I think it is a disgrace.

Dr. RICHARDSON. Congressman, I agree with you completely. Not only is it a moral outrage and a human tragedy, I think it is fiscally misguided.

I am often struck by not only politicians but all kinds of people telling us that in this era of limited resources, we just can't afford to pay for all of the things that physicians have a tendency to say we need. We are paying for it.

We are paying for it at the wrong end. We are paying to take care in a very expensive fashion all kinds of problems that a little bit of money at the other end would have prevented, just as it costs considerably less to fund a Head Start program for a child than to incarcerate them 18 years later when they have made all of the wrong choices, it is so much more efficient to pay for primary care than to wait until people become so unhealthy they develop a medical emergency, to pay for all kinds of public education and prevention techniques than to take care of these patients when they suffer preventable accidents or trauma.

Mr. SCHEUER. When they have dropped out of and are into crime and drugs and violence.

Dr. RICHARDSON. I think we all need to understand that we are making choices and we are paying for the choices we have made, and I think we are spending the money on the wrong things.

Mr. SCHEUER. It is not a question of pay now or pay later, it is really a question of invest now or pay later.

Dr. RICHARDSON. That is right. Somehow it is always harder to invest than to pay later.

Mr. SCHEUER. It is always harder to invest, but the payoff of society's investment in a Head Start program is like one to ten, for every dollar invested, we get $10 back in costs avoided, and the same thing for maternal-child health care, for prenatal care, postnatal care, child care.

Dr. RICHARDSON. I think that would be true across the board for some kind of real national health insurance program. I hope you gentlemen will be able to construct it.

Mr. SCHEUER. Well, I want to thank you, and I want to thank the Chairman for his very great courtesy and kindness for letting me have a few moments here with you before I have to move on.

Congressman Fauntroy, you have been an exemplary Member of Congress. You have provided enormous service to your constituents in Washington, and not only that, but you have had a national impact. You have been an adornment to this Congress, and I want to tell you how much I appreciate your courtesy this morning.

Mr. FAUNTROY. There will be no demonstrations in the hearing room.

Let me pick up for my final question on the point you just made. You have urged us to find some means of providing comprehensive health care for all American citizens. You have broached here an idea, however, that I want to make sure that I understand. That is, given the crisis in the provision of emergency services in our public hospitals and in hospitals generally, are you asking, should we not make emergency care an entitlement for those who show up at our public and private hospitals in need of care?

If we cannot have comprehensive Medicaid coverage for the poor, are you suggesting that any indigent person who shows up should, by virtue of that fact, be covered for that emergency need by Medicaid?

Dr. RICHARDSON. Well, I am saying that if we all agree, and I believe we do, that anyone who is presented with a medical emergency must be given the highest quality care that that institution can render to that person, then I think that we have to construct some reasonable way to pay for that care.

The hospital cannot simply continue to eat it, which is what has been going on for a long time, but I hope that you hear that we are saying more than that, and even at the risk of offending—well, actually I probably wouldn't, my 14,000 colleagues, emergency physicians, that probably even more important than making emergency care an entitlement would be making primary care an entitlement.

I mean, what I am really begging the committee to do is to keep them out of the emergency department, to take care of the health problems before they develop into emergencies, that that is really the only rational course that I think we can pursue.

Certainly in the short term to ensure the availability of emergency care you are going to have to put resources into the hospitals that are providing that care because hospitals, certainly the voluntary hospitals can, you know, physical entities, look at the emergency departments and see this incredible dollar drain that they are forced to take care of all of these patients who have no way of paying for their care by virtue of the fact that they have an emergency department, and we have seen a disturbing trend in some parts of the country of hospitals simply getting out of the emergen-

cy care visits. They simply close the doors to their emergency department.

We have seen an appalling withdrawal from the whole area of trauma care, that it simply is not a good business decision for a hospital to agree to take all comers with very expensive kinds of care, with these very labor-intensive and high-tech treatment modalities that these patients require. So you are going to have to put some resources into the emergency care system if you really want it available for everyone, but more than that, look beyond the crisis to really turning around, you know, the whole health care crisis to providing some way for all Americans to get access to primary care.

Prevention is so much cheaper than treatment.

Dr. KELLERMANN. We either need to have the means to provide necessary emergency care or you and society need to tell us who we are to allow to die. We have got to do one or the other. We cannot provide necessary emergency care and not have the funds necessary to support the provision of that care. and I don't think anyone in this room is comfortable with the idea of allowing someone to bleed to death or die of a heart attack without adequate intervention.

However, as Dr. Richardson has said, prevention—injury prevention as well as illness prevention—is cost effective. When Congress in the last decade repealed Federal mandates for motorcycle helmets and allowed the States to choose their own course, many States repealed motorcycle helmet laws. As a result, head injuries, mortorcycle-related fatalities, costs for emergency care, and chronic brain damage disability payments skyrocketed.

The decision was not fiscally responsible, and it was not humanly responsible just for the joy of feeling the air blowing your ears. But these are the kinds of decisions that have been made in the past and could well be made in the future. Many of the interventions we are talking about don't really cost money. Instead give them a better quality of life and ultimately the pay off is less need for acute health care services. We not only have to deal with the supply side and make sure that the supply of acute care hospitals and interventions are there, we also need to tackle the demand side. That is very fiscally responsible and cost-effective governing.

Mr. FAUNTROY. I am sure that no Member of this panel would disagree with both your assessments. Certainly, I agree with them. I did, however, have a vision—given your statement about what was really an entitlement of any citizen to emergency care of the best quality that can be provided by a given institution—a vision, for example, of Harlem Hospital having emergency Medicaid cards that were available to the persons they serve from which the hospital could be reimbursed so that as a teaching hospital they might provide scholarships for those who wanted to go into nursing and para-professional careers—point one and point two, through this method they might be able to raise the salary of the nurses who in turn would be attracted to an emergency room where there now are 50 percent vacancies. I am just wondering if I don't see a window of opportunity in terms of what you have testified to here by which, if we do nothing else, we say as a government that a person in need of emergency help from a heart attack, from a

stroke, from a broken bone, from an automobile accident, from a drug emergency or from a violence emergency has a right to be covered and that the institution providing that service need not be penalized, as happened in one hospital recently, where 400 health professionals had to be let go because, as a Nation, we are not dealing with this emergency care crisis that you have alerted us is about to become out of control throughout our country.

Dr. KELLERMANN. If we have a mechanism to provide a reasonable level of compensation to institutions—neither of us up here is here to talk about docs, we are here to talk about quality of care—that would make a tremendous difference.

At the same time, I think we have got to provide an environment that permits and encourages hospitals and emergency departments to direct nonemergency utilization to off-site or primary care locations.

Many emergency departments these days are too nervous to do that for fear they will be perceived as denying access to care, but if you do provide a guaranteed portal, you have to make sure that that portal is used by the patients who really need it and that a mechanism is in place for the person who comes in with a sore throat at 3 a.m. in the morning to be directed to a neighborhood clinic or to be directed to a primary clinic the next day so that we can do the job we are trained and dedicated to do, and our primary colleagues can do the job that they are trained and dedicated to do, but I think what you are talking about has a great deal of promise, and I hope that you will develop that idea.

Dr. RICHARDSON. Yes; I know that the American College of Emergency Physicians would be interested in pursuing such an idea.

Mr. FAUNTROY. Well, let me thank both of you, Dr. Richardson and Dr. Kellermann, for your excellent testimony, frightening testimony in many regards for the American public generally, but certainly not for the Members of this Committee who have watched this problem grow and grow, particularly in the last 4 to 5 years. Please convey to your national associations our appreciation for not only the quality of your testimony but the compassion and concern reflected in your delivery of it.

Thank you so much.

Dr. RICHARDSON. Thank you, Mr. Fauntroy.

Dr. KELLERMANN. Thank you, Mr. Fauntroy.

Mr. RANGEL. Our next panel is Dr. Emilio Carrillo, president of the New York City Health and Hospital Corporation; Dr. Michelle Reisner, director of emergency services, Jersey City Medical Center; and the executive director of the D.C. General Hospital here in Washington, DC, Mark Chastang.

Dr. Carrillo, we are glad that the shuttle allowed you to finally get into the Nation's Capital and hope you were present when I was sharing with Dr. Richardson the leadership role that the Health and Hospitals Corporation is playing in identifying how we can improve the health care of our city. I should have mentioned Dr. Myers as well, who was a part of that team, and working with the private sector.

So you can begin your testimony, and we certainly look forward to hearing everything that you have to say. Thank you for being with us.

STATEMENTS OF DR. J. EMILIO CARRILLO, PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORP., ACCOMPANIED BY DR. DOOLEY WORTH, SENIOR HEALTH ADVISER; DR. MICHELLE REISNER, DIRECTOR OF EMERGENCY SERVICES, JERSEY CITY MEDICAL CENTER; AND MARK CHASTANG, EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL

Dr. CARRILLO. Thank you, Mr. Chairman. Luckily the fog, overcloud lifted and we were able to get in to be here.

I heard your kind and wise remarks. I thank you.

Good morning, Mr. Chairman, committee members. I thank you for the opportunity to testify today on the impact of drug abuse on New York City and its health care system.

As stated, I am Dr. Emilio Carrillo, president of the New York City Health and Hospital Corporation. With me here today is Dr. Dooley Worth, my senior health advisor.

The magnitude of the drug crisis and the extent of our need to respond to it cannot be underestimated. Last year this nation witnessed the ravages of Hurricane Hugo. We saw people whose homes were destroyed, who had little food, whose places of work lay in ruin, and who suffered the physical injuries of the storm. Federal aid, along with support from countless individuals, was forthcoming.

What we face in this drug epidemic is much worse, much more devastating than Hurricane Hugo, a one-time occurrence. The drug epidemic is a continuum of devastation. The drug epidemic in New York City has left people without homes, without work, without family supports, faced with physical and emotional despair; children without parents; and communities in economic ruin. Why haven't we responded to this devastation with compassion similar to that extended to communities touched by Hugo?

There is a historical preference for considering drug abuse a criminal problem rather than an illness and a public health problem. This has resulted in the lack of a long-term commitment to treatment resources and preventive action.

For years, drug abuse has been thought of as a moral issue, an issue of personal failure of the will, and as a violation of the law. Drug abuse is however, a chronic, relapsing condition for which a continuum of different services is required.

Drug abuse is not just an individual behavioral problem. It is a symptom of poverty, racism, sexism, inadequate education and lack of employment opportunities, combined with the breakdown of traditional social structures in our most vulnerable communities.

Currently there is a trend to single out specific illicit drugs for treatment, education or interdiction. Such approaches fail because patterns of drug use are dynamic. New derivatives and combinations of drugs come into the market just as targeted programs are put in place.

By focusing on the impact of specific drugs, rather than the reason why so many people feel they need drugs, we have pursued mostly ineffective approaches to resolving this epidemic.

We need to study the process of addiction, the influences which initiate, drive and sustain it. We need to develop and evaluate

many new forms of drug treatment which address the long-term course of drug dependency.

New York City is an epicenter of the drug abuse epidemic. The only health care option for many addicted individuals is our city hospital system, a system traditionally geared to provide high tech, emergency and acute care. Sadly, we are better equipped to handle the gunshot wounds from drug-related violence than we are to effectively treat or prevent drug dependence to assist people attempting to lesson or stop their drug use, or address the impact of their drug dependency on their families, particularly their children.

An estimated 450,000 children in New York City are growing up in families with serious drug abuse problems. Resources that can and do prevent hospital stays, and divert patients from emergency rooms—community-based, prevention-oriented primary health care and comprehensive drug treatment have been neglected or poorly funded.

Drug abuse has inundated our city hospitals. It is estimated that New York City has 200,000 heroin abusers, about 40 percent of the total heroin abusers in this country; and 20 percent, or 400,000, of its cocaine, crack and other drug abusers.

Drug abuse in New York City is heavily concentrated among the young. Almost one-quarter of the city's drug abusers are children between the ages of 12 and 17. Our emergency rooms see younger and younger victims of gunshot wounds stemming from drug-related violence.

Therefore, New York City endures a much larger share of the costly public health consequences of this epidemic: increased violence, AIDS, homelessness, seriously ill newborns, overcrowded hospitals and compromised health care.

Drug abuse has also fueled an increase in the number of people coming to emergency rooms with psychiatric problems; emergency rooms which are already treating a growing number of homeless persons with problems resulting from drug abuse.

Increasing numbers of our medical beds are filled with AIDS patients who are intravenous drug users or their sex partners. AIDS and drug abuse are inextricably linked. At least one half of the city's 200,000 IV drug abusers are HIV positive, 100,000 individuals. More than 80 percent of the women and children with AIDS in New York City are infested as the result of indirect or direct contact with intravenous drug use. Most will receive their medical care in our hospitals.

Our neonatal units are overcrowded as a result of increased maternal drug use. The cost of intensive hospital care for each drug-exposed baby in New York City has been estimated to be $90,000. Our hospitals are filled to capacity at a time when they face numerous constraints in their ability to respond to an increased number of clients who are more seriously ill and clients who have multiple health problems, including addiction.

There are serious staffing shortages, inadequate reimbursement for an increased level of care, lack of primary care and post-acute care options, and grossly insufficient drug treatment resources. As emergency rooms are transformed into holding areas for patients awaiting admission, ambulances are diverted from hospital to hospital.

Despite concerted efforts over the last three years to stem this drug-related "medical gridlock," on any given night in New York City, some 350 to 400 people wait in hospital emergency rooms for an inpatient bed. This month, in HHC facilities alone, some 150 people could be found awaiting admission in our emergency rooms every night of the week.

The staff of emergency rooms work under highly demanding, highly stressful conditions, sometimes likened to working in a MASH unit. For example, staff at HHC's Harlem Hospital Center report that there is an average of two gunshot cases a day; it is estimated that more than 90 percent of these injuries are drug related. These frightening statistics are similar to those reported by other HHC acute care hospitals.

In addition, emergency room staff report that drug abuse, particularly the increase in multiple drug use, complicates the triage process. It is often difficult to determine whether a patient is experiencing a psychiatric break or a drug reaction.

Drug dependence and its concomitant medical problems complicates treatment decisions discharge planning and post-acute services referrals. Treatment where drug dependency is involved is more labor intensive and costly. Increased security costs are incurred as the use of crack and multiple drugs often produce violent, erratic behavior toward the staff and other patients.

Staffing shortages—recognized nationally, but more severe in New York City, and most intense within HHC, are compounded by the problems of emergency room overcrowding. While nursing shortages are most visible, similar shortages exist among other health care professionals, particularly among staff with expertise in drug abuse. There is an urgent need for substance abuse training for our hospital personnel. Such training is one component of appropriate and responsive drug services for those who are drug involved.

Delivering these services is a majority priority for the corporation. However, HHC cannot meet the complex needs of this population alone. Unabated, the pressures of the drug epidemic in New York City will result in more drastic bed shortages, continued overcrowding in our emergency rooms, displacement of patients traditionally served by HHC and further compromises for the health care of all of our patients.

I believe that it is important for me to clarify that the emergency room, our focus, is only one point, is only one point in the system. The system is a complex interdependent system with many parts.

We can think of it as a system, as a box. There is an entry point and there is an exit point. We can think of the emergency room as the entry point into this system. The rate of entry into this system is determined by the amount of preventive services out in the community, the clinics, the primary care services, the ability of people to have their treatment, their problems treated before they become serious. The box itself, the ability to keep that process flowing, is a function of the number of personnel available, the availability of social workers to get people moved expeditiously and in a healthful fashion in and out, and then there is the exit door, the exit out of the system.

We have dozens and dozens of patients who must stay upstairs in acute care beds because they have no place to go, because they are not well enough to go back to the kind of poor substandard housing that they had before. We don't have the step-down facilities; we don't have the chronic care facilities; we don't have the home health care. So when those patients of Dr. Richardson's in Harlem Hospital are waiting down in the emergency room, there may be some beds upstairs taken up by people who are ready to go out, but society has no place to put them. So when we address the prophetic emergency room, we must keep in mind that we are talking about one point in a fluid system where there is an entry, a middle, and an exit.

The Federal Government must target and expedite the delivery of additional resources to deal with the consequences of drug abuse and the lack of appropriate resources to respond to it.

We have to address the imbalance in our health care system, the inappropriateness of a reimbursement policy that is nonresponsive and systematically underpays for primary care, and a regulatory system which has precluded the development of a post-acute, after-care sector.

To address these problems, I recommend: Congress can work toward increasing access to those who are uninsured.

Congress can revise Medicaid policy to create incentives for physicians and other community health providers to serve Medicaid patients.

In the 1980s, public funds for drug treatment, prevention and education programs were reduced at the expense of an emphasis on law enforcement. There are long waits for treatment for those who cannot pay for private care in New York City.

Despite widespread recognition that prevention and education programs break the cycle of drug dependence, few Federal dollars have been committed for programs to achieve this. Many communities do not yet have drug education programs, and efforts to seriously study drug-taking behavior are only in their early stages. There is a need for new models, models which engage those at risk in their homes, their schools and their communities.

Congress can help by expanding the current Federal resource commitment to the treatment and prevention of drug abuse, and supporting treatment services such as community outreach, crisis intervention and drug-free services through Medicaid funding.

There are also serious shortages in both prenatal care and appropriately structured drug treatment capacity for women. To address these problems, Congress should increase funding through the maternal and child health services block grant, specifically for drug dependent women and their children and extend Medicaid coverage to include drug treatment services, as part of the services package available to pregnant women through extended Medicaid eligibility programs offered by the States, that is, PACP.

Having more education and treatment will not suffice, however. There has been a dearth of research into treatment methods that can respond to the change in drug use patterns and populations. Congress needs to appropriate more funding for research on what works and what doesn't, particularly for the patient groups and

communities which the municipal hospitals and Health and Hospital Corporation serves.

We are confronted with a national disaster. We cannot respond with a few provisions skimmed off the fat of other needed initiatives. We must decide that this is a national priority and respond quickly, comprehensively, and effectively.

The drug abuse epidemic is the national disaster of the 1990s. Unless we take immediate action, we will all be devastated in its wake.

Data regarding the effects of drug abuse on New York City's health care system and a description of the treatment programs HHC provides are outlined in the document entitled "Drug Abuse: Issues Affecting HHC," which you have all received today.

I wish to thank this committee for taking on this pressing matter. I look toward committees and leaders such as Congressman Rangel to provide the funding, leadership and creative strategies to help us recover from the economic, social and medical devastation the drug epidemic has brought to our inner cities.

Thank you.

[The statement of Dr. Carrillo appears on p. 87.]

Mr. RANGEL. Thank you, Dr. Carrillo. Dr. Reisner.

STATEMENT OF DR. MICHELLE REISNER

Dr. REISNER. Good morning, Chairman Rangel and members of the committee. My name is Michelle Reisner. I am the physician in charge of emergency services at Jersey City Medical Center. I would like to thank you and Congressman Guarini for the continuous support of our institution.

Located across the Hudson River, Jersey City is–an inner-city teaching hospital serving a multiracial population. It serves a large number of substance abusers, many of whom use the emergency room as a primary care physician as well as for true emergencies.

The emergency room is on the front line of the drug war. We see over 65,000 visits a year, the overwhelming majority of which are associated with substance abuse. The atmosphere on any evening in our emergency room is extraordinary, filled with dramatic efforts to save human life and confront the harsh realities of the street.

Substance-abusing patients are hostile, irrational, demanding of staff. You hear patients describe the latest crimes they have committed and the local or street combination of drugs that are available down the block.

It is in this environment that the true impact of drugs is experienced. The cases we have seen include drug overdose, assault, injury, abused and neglected children, 10-year-old children hooked on crack or cocaine, babies born addicted to drugs or suffering from withdrawal syndrome. Most alarming, however, are the increasing number of drug-related AIDS cases.

The high number of substance abusers in our area and in many urban areas has increased the number of individuals at risk for HIV infection. This relationship between substance abuse and HIV infection is especially clear in New Jersey. Intravenous drug use is

the original route of infection in 57 percent of our AIDS cases. The national rate is 28 percent.

The AIDS epidemic has also hit minority groups harder in New Jersey than nationally, where 44 percent of all AIDS cases occur in minority groups. In New Jersey minority cases account for 67 percent.

Jersey City is a short train ride from New York City, which is the epicenter of the AIDS crisis, as well as a major distribution site for illicit drugs. This has provided a lethal pathway to infection for many addicts and users in Jersey City.

This grim picture of rate of infection and disease is further compounded by the problems of poverty, ignorance, and an overburdened, inadequate drug treatment network. In Hudson County this epidemic has strained the resources of the health care system to the breaking point.

AIDS patients occupy at least one in every five beds at the medical center every day. In 1989, 57 percent of AIDS admissions to Hudson County were at our medical center.

In addition to the burden imposed by AIDS and drug abuse, the emergency department is used by local residents for nonemergency care due to the poor access to primary care services. As is typical for urban hospitals, substance-abusing patients and other low-income and indigent patients come to the emergency room for routine medical care when they can't obtain their methadone dosage, when they need a hot meal or a safe place to stay overnight.

These problems are complex, and there are no easy solutions. We must make more of an effort to come to terms with the escalating emergency room and general health care crisis.

The lack of adequate rehabilitation resources is very serious. The uninsured patient that we discharge from the hospital has no outpatient facility. There are no rehabilitation centers to send them to.

In general, more attention is to be diverted to substance abuse education, prevention, and rehabilitation, especially for young people. Without Federal support, urban areas like Jersey City cannot meet even the most basic health care needs of their citizens, much less win the war on drugs. If additional funding is appropriated to escalate the war on drugs and AIDS, I hope the allocation process recognizes institutions severely afflicted by this crisis.

Please help the inner cities.

Thank you for this opportunity to share my experiences with you on the impact of drugs and AIDS on urban health care facilities. Together, we need to increase our commitment to substance abuse, education, prevention, and treatment.

Mr. RANGEL. Thank you, Dr. Reisner.

[The statement of Dr. Reisner appears on p. 98.]

Mr. RANGEL. I now yield to Congressman Fauntroy.

Mr. FAUNTROY. Thank you, Mr. Chairman.

I simply wanted to present to the committee the next witness and member of this panel, Mr. Mark Chastang, who is 5 months into his role as executive director of our D.C. General Hospital. Therefore, upon his broad shoulders fall the bulk of the burden of dealing with the panoply of problems that have been outlined by the panel thus far in the District of Columbia. He has the responsi-

bility of directing our public hospital in a community that has the highest drug-driven violence rate in the Nation, the highest AIDS rate in the Nation, the highest infant mortality rate in the Nation, the highest percentage of border babies in the Nation.

It was my privilege to meet him at D.C. General Hospital in the border baby room when we picked up—that is my wife and I took home a baby born prematurely on February 7 this year, weighing 3 pounds, full of crack and cocaine. I want to report to Dr. Chastang as he prepares to testify that we took that baby home on June 1. We gave her the name Melissa Alice.

Having served on this panel for 10 years, I was far more anxious than my wife because medical experts have testified before us, heretofore, that we really don't know what to do with these so-called crack babies. We don't know what you may be taking into your home.

I want you to know, Mr. Chairman and Members of the committee, that all we did was to hug her and kiss her and wash her and clean her and feed her and hug her and kiss her and tell her we loved her, and 2 weeks later we went out to D.C. General Hospital for her first examination. The doctor took blood and urine tests, she scratched her head, looked back at the chart, said "I've got to do this again." She took another urine test and concluded that in 2 weeks we had loved the crack out of this baby.

That being the case, I want Dr. Chastang to know that this is one success story that flows from the tremendous burden you are carrying for a community which reflects in its experience most acutely the problems this committee is now addressing in this hearing.

Thank you so much for your help and I hope that my report encourages you to keep on keeping on.

Mr. SHAYS. Mr. Chairman, will the gentleman yield for a second.

I just wonder if the name Reverend in front of your name had anything to do with it?

Mr. FAUNTROY. There is no question about that, but it was more the compassion of a wife who had concluded that government can't rear boarder babies, that boarder babies need homes, they need families, they need love, and that government should not have to rear them so long as there are some of us who have rooms in which they can sleep and tubs in which we can bathe them, and most important, a reasonable portion of strength in which we can hug and kiss them.

I am a special hugger and kisser, and I can't wait to get home this evening, and, Mr. Chairman, I am looking forward to putting her in your arms this evening so that you can see what has happened to Melissa as a result of at least one person and one family addressing that problem. It is not a total answer to the problem, but I think it points out that all of us, by some means, must become involved in addressing the problems which this panel is laying before us and which Mr. Chastang, in a very special way, will present us now.

Mr. RANGEL. What an introduction.

STATEMENT OF MARK CHASTANG, EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL

Mr. CHASTANG. Thank you, Mr. Fauntroy. I thank you for your willingness to open your heart and your home to one in need. It speaks to the kind of individual you are, and we applaud you, and we wish that there were more out there who would be so willing and so generous of themselves. So thank you.

Mr. Rangel, other members of the committee, my name is Mark Chastang. I am the executive director of D.C. General Hospital. I am pleased to have this opportunity to appear before your committee today to describe to you the serious impact of the drug crisis in Washington on the District's hospital.

First, let me tell you a little bit about our institution. The D.C. General Hospital is an 183-year-old institution. It stands on the west bank of the Anacostia River. It continues a proud tradition of assuring that the District of Columbia citizens receive health care with compassion, dignity and respect.

We provide health care services to all citizens of the District regardless of their ability to pay. We have a teaching affiliation with both Georgetown and Howard University Schools of Medicine. Annually we discharge over 14,000 inpatients and provide approximately 200,000 outpatient visits. Of that 200,000, approximately 5,000 come through our emergency room.

The societal problem of substance abuse, which is so pervasive across our city, and so endemic to our primary service area, is a very, very serious matter before us as a community. For the purposes of my brief comments I will focus on the impact of the current drug crisis in the hospital's emergency room as it relates to trauma care. That is, serious injury.

Also, I will briefly review the impact of drugs as it relates to the phenomenon of border babies, children abandoned at the hospital by their parents. I emphasize parents. It takes two to make a baby; it takes two to abandon a child. We often think of abandonment as being something done by the mother, but it is indeed done by both those who created, the mother and the father of the child.

Trauma is the leading cause of death and disability in children and young adults nationally. Such injuries remain the leading cause of death up to age 44, killing more Americans age 1 through 34 than all other illnesses combined.

For purposes of this discussion, trauma is divided into two main categories: blunt trauma and penetrating trauma. Blunt trauma refers to trauma such as automobile accidents, falls, assaults with baseball bats, et cetera. Penetrating trauma refers to gunshot wounds and stabbings, that type.

D.C. General Hospital provides an extraordinary amount of care to persons who are traumatized. A great deal of attention has been focused on the dramatic increase of violence in the District in recent years. We are justifiably proud of the role that D.C. General, and in particular, our trauma service plays in reducing the loss of lives and the alleviation of permanent disability.

D.C. General was designated a level 1 trauma center in 1985 by a team of local and national experts. Level 1 denotes the highest tier

in the designation process, and is awarded to trauma centers with the highest level of commitment.

As prerequisite a level 1 designation calls for competent personnel that must be immediately available, state of the art equipment and services, priority access to sophisticated laboratory and radiologic facilities, as well as to the operating and other incentive care services. A level 1 center requires a strong commitment to education and research and quality assurance, all geared to a high level of excellence in trauma care.

D.C. General's trauma team is lead by an attending surgeon, trauma surgeon, which is available in-house 24 hours a day for the receipt, stabilization and definitive care of the trauma patient. In the wake of the dramatic increase of violence in the District in recent years our trauma service has been taxed to the limit. At this time I call your attention to graphs one and two.

Mr. Chairman and Members, do you have those before you? They are in back of the package, OK. This shows our strong experience over the last several years. As indicated in 1986, there were a total of 876 trauma cases, and as the graph goes down, probably 26 of those were blunt trauma, baseball bats and that sort of trauma.

Penetrating trauma were stab wounds and that type of thing. As you can see, in 1986 there were 876 trauma cases, and in 1987 there was a fairly dramatic increase to 1,077. In 1988, there was a significant and dramatic jump from 1,077 in 1987 to 1797 cases of trauma in our emergency room.

Also, I call your attention to the increases in categories of trauma. We see that in 1987 blunt trauma was significantly more than penetrating wounds, but you see in 1988, that penetrating wounds, that is gun shot wounds and stab wounds, took, a dramatic surge forward, and in fact equaled blunt trauma. If you look at the figures for 1989, penetrating wounds began to outdistance blunt trauma.

1989 represents an unprecedented level and increase in trauma activity at D.C. General Hospital, totaling 1,920 such cases. From 1990 there has been somewhat of a decline, back from 1,920 cases to 1,800. What this graph actually shows is the penetrating wounds that began to increase dramatically in 1989, again, are the dominant source of trauma in our emergency room. What it suggests to me is that the District became markedly more violent in 1988. There was a major surge forward in brutality and reckless disregard for human life.

We are absolutely certain that it was fueled by the drug crisis in our community. Unfortunately, this callousness among our citizens persists, and it is increasing at an alarming level for 1990, as illustrated. Another very telling statistic is that approximately 65 percent of all of our trauma victims at D.C. General test positive for toxicology screenings, that is drug tests.

Drugs are in their system. Clearly, drugs of all kinds are a major causative factor in the hospital's current trauma experience. Let me call your attention to a second trauma statistic, graph two, which illustrates and presents the gunshot wounds as a percent of the total trauma cases. In 1988, we saw a tremendous surge in gunshot wounds from over 1987, from 180 in 1987, to 550 in 1988. To an

impressive 702 in 1989, it has declined somewhat in 1990, but it is still at an alarming rate.

These figures point out I think in a very graphic way what has become of our community, and unfortunately it is just not common to the District of Columbia. It is happening all over our Nation. Gunshot wounds made up 34 percent of all trauma for fiscal years 1989 and 1990.

The second critical service that I would like to call your attention to is that of maternal substance abuse, abuse of drugs by mothers. A second critical service where the current drug epidemic is dramatically impacting on D.C. General Hospital and other hospitals is maternal and child health services. We are experiencing a steady increase in a number of mothers who are abusing drugs when pregnant.

I would like to call your attention to graph three, percentage of infants born to substance abusers. As illustrated, dramatic increases have occurred since 1987. In 1987 we had 1,830 births at the hospital, and 10 percent of those mothers abused drugs. In 1988, we had 1,815 births, and 18 percent of the mothers abused drugs, and in 1989, we had 2,024 births, and 20 percent of the mothers abused drugs, and that trend up continues into 1990. We are projecting with significant certainty based on the 11 months data we have, that the trend continues up, 24 percent of the 2,202 births of mothers abusing drugs.

The impact of this problem is far reaching. A more extensive and intensive medical care is required to treat those individuals, and most importantly, most are abandoning their children at birth. Our statistics indicate that 90 percent of the babies abandoned in our hospital are from mothers who abuse drugs, crack, cocaine, heroin, PCP, and other drugs.

I call your attention to graph four, D.C. General Hospital boarder baby experience, which is an illustration of a 13-month experience with boarder babies. Beginning in June of 1989 where we had 15 such babies abandoned in the hospital for that month, and you will note that in October, November, and December there is a significant climb. The President visited the hospital and after his visit there was an outpouring of interest in adopting and taking care of children, and that is what that represents, and it has gone back up again, and we are seeing another surge in this alarming statistic.

These infants are immediately ready for discharge, but no one to care for them. The average infant stay is 124 days for these babies. The longest stay was about 214 days, or over 8 months. Forty-three percent of these mothers receive no prenatal care. Ten percent of these babies are HIV positive. Fourteen percent had other special needs.

At this sitting, we have 10 boarder babies in the hospital's boarder baby room at this very moment, and others in the ICU unit that we know will be coming in as soon as there is room.

I would also like to call your attention to yet another graph, graph five, which speaks to the issue of the impact of substance abuse on the hospital, D.C. General and others throughout the country where drug abuse is quite common, similar statistics can be presented to show evidence of the impact. As indicated by the dissecting of the chart, impact of substance abuse on D.C. General

Hospital outlay cost, we see that trauma for fiscal year 1990 represented $26 million of our operating budget, boarder babies cost another $1.8 million. Neonatal services is another $8 million, HIV and related care, $1.7 million, and substance abuse, which is a separate general category, we have an in-patient unit at the hospital, representing $4.7 million.

That is an example of two dramatic impacts on the hospital, there are many more, and I underestimated the amount of time available to us, or I would have provided you with an exhaustive commentary on this critical social issue.

Let me just comment on some of the recommendations that have been spoken to in part by other members of the panel. It appears that for a number of reason, rightly or wrongly, that national health insurance won't become a reality any time soon, so the question becomes, what should we do to address the current crisis?

I ask you to consider the following, some of which hasn't been spoken to earlier, and I am speaking perhaps somewhat selfishly as the executive director of my institution, and more a microsense than a macrosense. But concerted effort must be directed towards expanding the capacity and capability of those public and private sector hospitals; there are some private sector hospitals that provide a disproportionate amount of care to the uninsured and those persons who are victims of a current drug epidemic. But the capacity and capability in those public and private sector hospitals that provide disproportionately higher levels of care to the uninsured, and Medicaid recipients, must receive additional financial support, and I will talk a little more about that in just a moment.

Medicaid must be expanded to include greater numbers other than 37 million uninsured in this country. Some of the particulars in the medicaid program that are particularly troublesome here in the District and discourage area hospitals from serving Medicaid recipients is that the time determination for eligibility and the reimbursement process is slow, for the reason of saving money and saving funds and deferring to future needs, Medicaid payment from the Department of Human Services which administers the Medicaid program here in the District of Washington, and that is probably a similar tactic to save funds that exist around the country.

So streamlining the process of reimbursing hospitals, making sure that the averaging of the payments to hospitals is if an error is made, it is made on behalf of the hospital, rather than on behalf of the agency that is administering the program.

We receive a flat fee for Medicaid, and a utilization projection is provided based on the previous year's utilization. Invariably for the last 5 years we have been under paid, and the way this under payment is handled, it is addressed in a cost settlement. The cost settlement is determined based on cost reporting documents that are submitted, and then we dicker back and forth, and then we agree on the final dollar amount that is owed to the hospital.

Right now the District of Columbia, the District of Columbia Hospital Association is bringing suit against the Medicaid program here to encourage them to force them to pay area hospitals, the public hospital as well as a number of private hospitals, those funds that are the result of services rendered to Medicaid recipients that are owed from past years.

Our payments go back to 1985. We are approximately, D.C. General, approximately $8 million for Medicaid services, and the total amount for District hospitals is over $50 million, not including interest. If there could be some sort of standard requirement, nationally, that Medicaid payments to hospitals be streamlined, and if an error is made, make it on behalf of the hospital then settled up later, the Medicaid programs can always credit the hospital, that is reduce future payments, in order to retrieve any other payments they may make initially, but that is not the case in the District and probably not the case throughout the country, so that is a very specific change that could be made that could help hospitals with their cash flow and with the overall fiscal positions.

The other very broad area I think is in education, and this gets me into trouble every time I make these comments, but I think it is appropriate to do so. Many of the problems that are seen in emergency rooms and in our hospitals throughout the country are the result of troubled lifestyles. That is, we have individuals who choose to pursue poor nutrition, to use drugs, to use alcohol and tobacco in excess. We have one of the most sophisticated advertising industries in the history of civilization encouraging this. As I flip through, as I do weekly in Jet and monthly in the instance of MM, it is for advertisements for alcohol and cigarettes and the like. This advertising strategy and this encouraging of our people to abuse and to live poor lifestyles really predisposes many of them to the likelihood of winding up in one of the emergency rooms across the country.

Perhaps what we should do is to launch a major counter initiative which discourages the use of drugs, alcohol, smoking to excess, because what it creates is on the one hand, individuals need care but they have chosen to predispose themselves to care, and are wanting the public and the taxpayers in those instances, particularly people who are uninsured to pay for that care, and that creates a very difficult dilemma in terms of how limited resources are to be allocated.

But it really gets at the crux of the issues that we are discussing. We must be balanced in our approaches and our recommendations and realize that there are not very many resources to go around.

That concludes the main points that I want to make, Mr. Chairman, and I very much appreciate the opportunity to come before you to address this important issue.

Thank you.

Mr. RANGEL. Thank you, Mr. Chastang.

[The statement of Mark Chastang appears on p. 103.]

Mr. RANGEL. The purpose of these hearings was to show the impact of drug abuse on the quality of care that is available in emergency departments throughout the country. I think that the testimony that we received today dramatically shows that, since I assume that all of you agree that whether you are an addict or not, whether you live in the city or not, whether you are rich or poor, the ability to get quality emergency care is dramatically reduced because of the problems that we have with drugs.

Is that correct?

Dr. CARRILLO. That is precisely right, Mr. Chairman. The problem spreads to the entire society, and it is very taxing on our

system and affects our ability to treat the entire system, and not just, not just speaking of the municipal system which I represent in this case.

If our emergency rooms are filled, the overflow backs up into the private hospitals, and the private hospitals get full, and so on and so forth. Our ability to—our emergency medical services, our ambulances, are also taxed.

Our ability to respond to a heart attack in less than 6 minutes is taxed. So for the mightiest to the poorest, the mightiest may be having his heart attack on the 50th penthouse suite, to ability to get that 6 minutes into the emergency room is also affected.

So, you know, don't ask for whom the bell tolls, it tools for thee. This is a problem that affects each and every one of us in this society.

Mr. RANGEL. So even if the President of the United States, as he—or is he campaigning today, I forgot, but wherever he is campaigning, if indeed he is struck in an emergency, that doctor who would welcome the opportunity to, he, or she, to respond to the leader of the free world, may have to pass by people with gunshot wounds or people throwing up or addicts pregnant, or just old sick folks that are looking for care.

So, while there is a lot of emphasis on the amount of money it costs, basically the testimony I have heard is that you try to unclog the compensative part of the system by keeping out of it that shouldn't be in it in the first place, so that you can get back to where the pride and the expertise and indeed the leadership has been to take care of emergency cases as we used to know them.

Now, I received a telephone call from the chief of staff indicating that I had been unfair in saying that the administration had no strategy to deal with these types of things. I called up that particular secretary and said that I am more than anxious to publicly apologize to any cabinet official if they could just show me, where is this educational piece that Mr. Chastang was talking about that I could then go back and tell my players and my Governors that instead of begging for money if you do what they tell you to do, with the programs that we have locked into place in education and prevention, you wouldn't have all of these problems in your jails and in your court system, and in your hospital emergency ward.

Now, I have looked through, because I don't want to publicly apologize, but I promised that I would, and I am asking staff to try to pull out there this program is so that, so I can apologize.

Then I also said that if there is a Federal treatment program for any type of addiction, that the secretary can put his fingerprint in and say those are the type of things I like to see duplicated in our district, Rangel, instead of running off at the mouth, then I will apologize there too, because these people shouldn't be in your emergency ward. They should be in some rehabilitation center. But nobody had told me what modality, what research has been done, what direction to go.

Now we are the leader of the free world. We got people—we just left of the President of Colombia. These people are asking us what to do. I am asking you that, do you feel the presence of the Federal Government in giving you assistance in rehabilitation so that your doctors won't have to deal with this?

Dr. CARRILLO. Perceptively absent.

Mr. RANGEL. Then I would not embarrass you to ask you what is rehabilitation, because Dr. Richardson eloquently said, it is clearly more than health care.

Dr. CARRILLO. Precisely.

Mr. RANGEL. So that piece is missing. Let me—in addition to dramatically showing the problem we face, I also want to be a part of the solution.

I have asked staff to contact all of our witnesses to see whether we could get some people that maybe are more powerful than the Congress to come together to kind of see how we had talked about not spending more Federal money by just expanding programs, but seeing how we could best spend the money that we do have.

Everybody has made it abundantly clear to me today that we do better preventing a lot of these serious illnesses through community type of health care programs, than waiting for someone to get a $1,500 a day intensive care bed or a cheaper $600 a day bed in the hospital, and God knows what the hourly rate is for emergency health care.

I am going to ask for a meeting, and I am certain that Larry Coughlin joins with me, although I haven't shared it with him, but the American Hospital Association, the American Medical Association, the College of Physicians that deal with emergency care, some of our teaching hospitals to come up with more research that we can come up with a package and say that we know that you have a budget crisis, but all the statistical data clearly shows that we are having more babies addicted to drugs, more patients in his intensive care, an explosion of people getting treatment that we don't know whether the treatment is working, and that is something that I wouldn't even think about asking the Secretary of Health and Human Services.

The reason I don't is because I don't have enough courage to ask my State division of drug abuse, much less going into my community and ask the question, is what you are doing for these addicts really working? Oh, does that take a lot of political courage to ask that, because the answer is we are doing the best we can and we don't have the resources to do an effective job.

If lawyers did that, you know, they would be indicted and be in jail and rightly so. I went as far toward your acquittal as I could, but you know, we didn't have the money, so you don't know how much time you would have gotten if I wasn't there at all. This is what we have been asked to accept as it relates to providing health care for people who are sick and addicted to drugs.

I do hope that you will participate. We politicians will withdraw and let you come up with a plan; we will give you people from the Office of Management and Budget, we will bring you people from the Congressional Budget Office. There is no question that Dr. Sullivan's staff will participate, and maybe we can walk away and say budget crisis you have, but the people are getting sicker, the ability to provide services are becoming slimmer, and we are still going to have to pay for money for them.

This has been an excellent panel as the preceding panel, and this in my opinion would only be the beginning of the process to see whether we can find some solution to this. I want to sincerely

thank you, not just as a Member of Congress, but as someone that is far more involved in this problem than I wish I was.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman.

I join in thanking both panels that have been here. I do apologize that we had to be absent briefly for a meeting with the President of Colombia. In addition to working full time, my wife spends a lot of hours each week doing volunteer work at the Children's Hospital here in Washington, and the number of crack addicted babies and boarder babies is just appalling. Although it is somewhat beyond the purview of emergency room discussion, many of these are multiple birth situations.

Would you favor some sort of civil commitment for treatment of those who produce crack addicted babies or who are unable to care for their children because of drug addiction? This is a tough question, I know.

Mr. CHASTANG. That is a very tough question. Are you suggesting requiring treatment of the patient, the mother, and some sort of instructional requirement for the father of the child?

Mr. COUGHLIN. Yes.

Mr. CHASTANG. That is an interesting idea. I am sure the lawyers would immediately raise the question of whether or not you are infringing on that person's right to do or not to do the drugs.

I mean that is the first question that comes to mind. It is a very difficult question, I am sure from a legal perspective, not from an emotional perspective, but it certainly raises an interesting idea.

One that should be pursued and thought through.

Dr. CARRILLO. May I add to that? Let me just say that we do not have sufficient treatment facilities; we have long waiting lines in may treatment facilities. The cost of treatment is far less than the cost of criminal process and criminal interdiction, and I think that if we have any resources, the resources should go towards treatment/education rather than the latter.

Mr. COUGHLIN. We have substantially increased the funding for treatment and have put a greater emphasis on treatment than has been true in recent past years.

The question remains on how to get people into treatment, because very often people don't necessarily want to enter a course of treatment or don't follow through and take the complete course on treatment.

Dr. CARRILLO. Well, in New York City, let me say that we have long waiting lists for methanol programs which the methanol programs we have available, which only 15 percent of the heroin abusing population in New York City, and other drug treatment modalities are only available to about 2 to 4 percent of the non-narcotic abusing population, that is cocaine and crack.

So in New York City, we are woefully, woefully under supplied with drug treatment facilities.

Dr. REISNER. In New Jersey we don't have much in the way of prevention, but in terms of rehabilitation, our hospital does have a federally funded AIDS program for patients with AIDS that is extremely successful and has decreased the number of acute AIDS admissions.

We have far less patients being admitted for acute episodes of pneumonia, improved life span of AIDS patients due to the rehabilitation clinic.

Mr. CHASTANG. I recall an interesting radio program broadcast that I participated in where a caller called in and offered I think an interesting idea. We thought it was laughable at the time. But suggested that the drug abusers who enter a program be paid at the end of the program. If you can stay drug free for 30, 40 days, give them $5,000, and enter into a partnership with companies that are perhaps looking for persons who want to turn a corner offer the $5,000, and a job, and as long as they can stay drug free, you continue to give them some incentives, financial incentive, and to make sure that they have a support system that is a job and a family to go to after they go through this crisis.

We thought it was laughable at the time, but I think it is something that should be pursued as an idea, a major incentive.

The thing that is most difficult is that the individual has to decide that this is something he or she wants to do. They have to make a critical, emotional decision to do this.

The other, I think, resource in our community that we really should tap into is the church. Many of the churches have access to people who are having this difficulty. We need to have a national network of churches involved in identifying individuals who need help and don't know how to find it.

If that includes letting individuals come from Mobile, AL, to Washington, DC, because the resources for intervention are here, then so be it, but again those—and incentive program, perhaps even an official incentive for people enrolled, the assurance of a job, a meaningful job as they come out. Then, second, to enlist the support in contacting individuals who have problems, who are out there and want help and don't know how, through churches, I think those are some opportunities that are worth exploring further.

Dr. CARRILLO. If I may add one more thing, to put on my other hat, that of a primary care internal medicine physician, in my experience in Cambridge, Harvard Medical School, prior to coming back to New York City I often had the situation of a patient walking into my office and saying, "Doctor, I can't stand it anymore. My family is falling apart, I lost my second job, I really want to get off this cocaine. I want to get off this crack. Can you help me, Doctor?"

I get on the phone. I make five phone calls, 10 phone calls. I ask the nurse, "Help me, nurse, make some phone calls." I go to the clerk; we can't find a bed for the person. Guaranteed that person is going to go back to the drug that night if I can't get a bed to them.

Do we cure the person by putting them into that drug treatment facility? Perhaps not. We give them another chance.

It is a very difficult condition to treat. There are no magical solutions. However, as in the treatment of alcoholism, which has some similarities and many differences, the AA philosophy, "one day at a time," you try, you believe, you need the support of the community, support of your family, support of your doctor, and we have to look at it, I think.

I mean, as a society we understand alcoholism a lot more than we understand drug abuse, that there is no magical cure, there is a lifetime commitment and there is trips and falls and getting up again and trying again, and I think that we have to do the best we can to come up with the kind of resources that will give the possibility for people to have treatment for something that is so difficult.

A study was recently done in New York City that showed that over 70 percent of drug treatment programs that are available refuse entry to women who are pregnant, so women who are pregnant who want to get into a program because of the fact that they are pregnant, despite the fact that their need is even greater, they can't get in. So we have some real holes in the system.

Mr. COUGHLIN. Let me just follow up with one question, if I might. You have mentioned Medicaid funding for crisis intervention services and for outreach services. Is Medicaid funding presently unavailable for those services?

Dr. CARRILLO. Many, many types of crisis intervention services will not be funded by Medicaid, a great deal of them.

Mr. COUGHLIN. Thank you, Mr. Chairman.

Mr. RANGEL. Mr. Shays, did you say you would yield to Mr. Fauntroy?

Mr. SHAYS. Yes.

Mr. FAUNTROY. Thank you.

I simply have one question which relates to an experience I have often with my wife who, while she appreciates political life, does not like to do certain things that are thrust upon her as a political wife. She often says to me, "How would you like it if somebody forced you to be a doctor?" She says that because she knows that I can't stand gore, I can't stand to see people in pain, and I could for no reason serve in an emergency room.

However the thing that has puzzled me is whether emergency staff in hospital rooms, in addition to the stress they have to obviously watch and handle, are not traumatized by the fear that with respect to drug-driven violence someone might break into the emergency room from another gang to finish off a job that they had not done very well.

I say that in raising the question against the background of Mr. Chastang's reference to the fact that in 1989, we had 702 gunshot treatments at D.C. General and that it has dropped to 600 in 1990. That drop to 600 was probably the result of greater marksmanship on the part of those engaged in this bloody business because the murder rate in the District of Columbia related to violence, to drugs has, in fact, increased since the record year of 1989.

So the bottom line question is, how do your emergency staff personnel feel about handling this new element and the stress that they have to handle in an emergency room?

Dr. REISNER. As I mentioned, the substance-abusing patient is not only very sick, he is also hostile, irrational and extremely demanding, and it is not uncommon for them to threaten the staff.

Another fear is the spread of AIDS via needle-stick injuries. How we handle it is really by a support system. I would like you all to be aware of the stress, in the emergency room where there really is a drug war going on.

Mr. CHASTANG. We find that the kind of individuals who go into the practice of medicine, and particularly those who work in emergency room settings, are a special kind of people. They are committed to helping others, they know what they are in for, and they choose to be in this environment.

So we have at D.C. General a very capable and skilled and competent and committed group of people, core group of people who are there because they want to help others and they want to be there, but notwithstanding that is still very stressful for them and we, too, as the doctor expressed, make special efforts to be supportive of them.

There is, however, a great deal of stress, as you can imagine. There are in instances threats of physical harm to the persons who are attempting to help the individuals, as ironic as that might seem, but I think that is something that would be a very interesting area to explore and analyze and develop recommendations around as a way of saying, number one, thank you to those who are out there in the front lines and the trenches every day, but also as a way of encouraging others in the medical profession to consider going into the emergency rooms who are in such a tremendous need for expertise and medical intervention. I think that that is an excellent area that has gone unresearched, and no concrete recommendations developed around, but as you indicated, Congressman Fauntroy, it is a very stressful area, one where physical violence is possible.

It has not, thank God, happened at D.C. General Hospital, although we have had other incidents where inmates have done things violent to the staff, and they bounce back because they care, they love what they are doing and they love helping people, but it is something that I think should be brought front and center, thanking the people who work around the country.

I mean, the President, maybe this committee needs to send a special letter to the emergency room staffs all around the country saying, "We know you're there, we know you're committed, we know you're doing an excellent job. Keep up the good work, and we are going to look into this in an attempt to find ways to be more supportive of you."

So D.C. General Hospital as well as all hospitals around the country have very capable and dedicated staffs who are giving of themselves every day.

Thank you.

Mr. RANGEL. Mr. Shays will yield to Mr. Guarini.

Mr. GUARINI. Thank you, Mr. Chairman. Thank you, Mr. Shays.

I wanted to not only welcome the whole panel but particular Dr. Reisner, who comes from my home area and has been the director of emergency services at Jersey City Medical Center and has been doing a great job.

I want you to know, Doctor, that I have read your testimony and I appreciate the efforts that you are making serving in those front lines that was just described in the war against AIDS and drugs.

I have had opportunities to visit the hospital and know the good work that is being done, and your heart does go out to the border AIDS babies and to see that one-fifth of all hospital beds in the hospital are AIDS patients and to know how much good work is being

done in the testing facilities and all the dedication that exists with the doctors and nurses and staff of the Jersey City Medical Center, so I really want to particularly thank you for being here and for your testimony and for your good work, and recognize the fact that Jersey City is the epicenter, as you stated, between New York City and Newark, which have high rates, Jersey City lies right in the middle there, and where the emergency AIDS and the funding bill was defined as 0.2 percent of the population.

We have more than 25 percent of the population of what we know and is probably even greater than that, so we do have an epidemic that is raging in your area and the funds are very, very short for the work that has to be done, and the burden that the public hospital is taking on to try to attend to the problems of the border babies and the AIDS patients and the testing and the counseling and all the other social services that you do give as a total package.

Let me ask you, is there, even with what has been said about the good people who have been working in the agency hospital, is there a difficulty getting doctors to work in the AIDS emergency rooms? Is there any resentment toward doctors in dealing with AIDS patients?

I would like to ask you that question in regard to nurses and staff because the personnel problem is an important problem. You need the money, but if you don't have the people that are going to be working there and if you are short on staff because of the type of work it is, and it is very difficult and thankless work to be in an emergency room, and you have to be there to understand how harried the existence is of somebody that is working under those kind of pressured circumstances.

What is the personnel problem that exists in the hospital concerning emergency rooms?

Dr. REISNER. In the emergency room we have medical students rotating through the emergency room who do not want to examine AIDS patients.

When you discuss the problem with the medical students and ask them which fields of interest they will be going into, there is no interest in primary health care services on the part of medical students.

In terms of getting nursing and other paramedical help, it is extremely difficult. There is a constant nursing shortage.

It is impossible to work in an emergency room when you have stretchers full of patients with one nurse.

Mr. GUARINI. With all the difficulties of working circumstances you have in the emergency room, do you find that it is difficult to get doctors to staff these emergency rooms? Is there any resentment on the part of doctors to treat AIDS patients?

Dr. REISNER. Doctors want to work less and less in city hospital. There is a drive to suburban hospitals rather than inner-city hospitals.

Mr. GUARINI. The AIDS cost in an emergency room perhaps escalate the size and the cost expenditures of emergency rooms that the public hospitals have difficulty meeting those expenditures. Is that true?

Dr. REISNER. We have great difficulty meeting expenditures. I would say approximately 40 percent of all our patients are uninsured, what we call self-pay.

In terms of resources AIDS patients come in extremely ill, and even when they have recovered from their acute crisis they have nowhere to go.

There is one AIDS rehabilitation center in the whole State of New Jersey. The waiting list is approximately 6 to 8 weeks.

Mr. GUARINI. Well, lastly let me ask you, in regard to the projections in the future, if the burden of expenditures and the difficulty with personnel is at the level it is now, what do you see in the future and what kind of projections are you making in order to handle the problem as it exacerbates and increases? Are you making any provisions or how is the future being provided for, if at all?

Dr. REISNER. I think "if at all" is the question. The projections are we need better rehabilitation resources—also, money to prevent disease and teach the community.

Mr. GUARINI. Thank you very much, Dr. Reisner.

I want to thank my colleague, Mr. Shays.

Mr. RANGEL. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. I appreciate your holding these hearings, and I appreciate the three individuals on our panel coming to describe what you live with every day.

I had the opportunity to meet on an individual basis with the seven hospitals that are in the fourth congressional district, which I represent in Connecticut, and the message that I hear from you is reinforced by what they say, but clearly we have a greater problem in our very core of urban areas.

I wanted to ask you, and I am trying to nail this down because I am hearing that with our 36 million uninsured and our 30 million underinsured, when a patient comes to an emergency room, they are not going to be turned down, that is accurate, isn't it? They are going to get that treatment whether or not someone has insurance, correct?

Dr. CARRILLO. In the municipal sector, the public hospitals, those which I represent, they will never be turned down. I think that some of the panelists earlier this morning pointed out that in the past there has been the issue of so-called patient dumping from private hospital emergency rooms out to other places which appears to have leveled off, but I personally cannot say that unequivocally that this does not happen in private hospitals.

Mr. SHAYS. Let me just say, maybe the differences in the district I represent with our seven hospitals, all of which are private, they don't have anywhere to dump to, so they take those patients.

So what I am hearing, then, I guess, is where there might be a municipal hospital that is forced to take a patient, a private one might, but in every instance, at least in the area I represent, what they have to do is absorb that cost by having the insured pay for the under-insured or the uninsured.

What I am trying to get at, though, is that they are going to get the treatment in the emergency room, but are you going to be finding ways to just simply clear them out of the hospital as quickly as

possible? I mean, not that you want to, or do they get treated as if they were like any other patient who had the money to pay?

Dr. CARRILLO. The doctors that I have come in contact with, hundreds and hundreds of doctors in the private sector, the public sector, I have yet to meet a doctor that will openly, in a clear way, sort of violate the ethic of treating all people the same.

Now, when you talk about extensive procedures, when you talk about open-heart surgery, when you talk about certain kinds of testing and procedures, there might be more of a bias. That has been documented by various studies, but the ethic is such that it is difficult to see in the primary care setting certainly that kind of an attitude.

Mr. SHAYS. Do the other two panelists agree with that?

Mr. CHASTANG. Let me comment on a couple of things. The structure that you might find in the hospitals in your district from one to one may be different.

For example, some of your hospitals might not even have an emergency room, and so the likelihood of that hospital receiving someone or treating someone who is uninsured is much less than a hospital that does have an emergency room, okay? For example, prior to coming to the District I was at a hospital that didn't have an emergency room, and all of the patients who were treated there were referred from community physicians, and they all had insurance presumably. The bad debt for that hospital was less than 1 percent.

Mr. SHAYS. I don't have that in the district I represent, but it is good for me to know there are hospitals like that.

Mr. CHASTANG. OK, the other qualification I might suggest to you is that some hospitals, when their emergency room capacity has reached its limit and has gone beyond its staffing capability go into a status called reroute, where persons who might be in a stabbing or be shot out in the community and who are picked up by the public ambulance service would not—they would be searching the network of hospitals for a hospital willing to take this person, and they would not take the patient to that hospital but go to the next hospital that had available capacity. So you asked the question earlier, would a hospital refuse to care for a patient.

In the instance of a hospital being overloaded, its capacity being exhausted, it would call the ambulance service and say "don't bring any more patients to me," and go into a reroute status, and then that patient would go elsewhere.

What has been found in some cities around the country is that hospitals have falsely reported being in reroute, thereby discouraging the possibility of uninsured individuals getting into their system and being treated. But if, for example, someone were to be driven by car into their emergency care and had insurance, they would miraculously have the capacity to receive that individual. So there are some qualifications to answering your question in that there are ways to get into hospitals for private persons that uninsured persons don't have those same accesses, but by and large in the public sector, 99.99 percent of the time, any person presented, insured or not, would be treated.

Mr. SHAYS. They would receive acute care but not necessarily long-term care?

Mr. CHASTANG. That is correct. We are an acute-care hospital, for instance, at D.C. General, and unless a patient is in the hospital for an acute-care need, and after the acute care experience is completed, there is no nursing home bed, for example, to send them to, they would remain there until one became available, but if they were in need of nursing home services while they were at home, for example, we would suggest that they receive those services from one of the area nursing homes rather than the acute-care setting.

Mr. SHAYS. The hour is getting late, Mr. Chastang. I just wanted to ask you about this chart because it relates to what I tried to understand from the earlier panel. Just take out everything that is not related to drug abuse, but the trauma care, the stab wounds and so on, just take this last chart here, and isolate the rest. I am just trying to sense, are most of the patients that you get that are drug-related based on the fact that they are drug users or is the challenge in our urban areas, the violence and so on?

I mean, is it 50/50, is it weighted 60 percent towards dealing with patients who have been stabbed or bludgeoned or whatever?

Mr. CHASTANG. Sixty-five percent of the patients who come to our trauma center, were treated in our trauma center, have drugs in their system at the times that they are treated, so well over half of the individuals are involved in drugs in some respect.

Mr. SHAYS. OK, but obviously the substance abuse of 4.7, the HIV is drug related, the at-risk OB neonatal, a good portion of those are drug related?

Mr. CHASTANG. Yes.

Mr. SHAYS. Obviously, the boarder babies, a good number of those as well?

Mr. CHASTANG. That is correct, that is the impact on our operating budget of substance abuse for fiscal year 1990. It is dramatic.

Mr. SHAYS. It is dramatic.

Mr. Chairman, I am done. Thank you.

Mr. RANGEL. Walter Fauntroy got my attention by just saying just what a great panel this has been and the contribution that you have made, and I responded to him by saying that this is just the beginning because we have got to find some solutions, and we need not just you, but the organizations that you are a part of to come forward to assist us in letting the Congress and the administration do a better job.

Dr. Carrillo.

Dr. CARRILLO. If I have a chance to respond to a question that was raised by Congressman Mfume——

Mr. RANGEL. Congressman Fauntroy.

Dr. CARRILLO. Yes, the question that was raised earlier regarding the recruitment of doctors, whether there is a problem getting doctors and et cetera. I think it is important to look at this closely because an issue that was raised by the Chairman, Congressman Rangel earlier, regarding the medical schools and the affiliations is very critical.

The philosophy of most medical schools in this country is not in the direction of primary care community services. Basically these medical schools do not have within their educational philosophy primary care, community health care, and even emergency care as

to their priorities. The students are not oriented towards these areas. That is a very important thing for us to realize.

In terms of our ability to recruit doctors to work in Harlem out in the health centers, off site, in the heart of the community where the prevention really takes place, the university will not give those doctors the same kind of academic status as the doctors who work within the hospital. There is a two-class system imposed by the medical schools in terms of the way they credential, the way they give academic credit, and the privileges that are given to one type of doctor versus another type of doctor.

It is also important to remember what happened over the 1980s to medical education funding, what happened to the scholarships, what happened to the loan programs. There was a big change in this country from the late 1960's, early 1970's to what happened in the 1980's. Just remember that it was possible for many minority students and for many working class men and women to go to medical school on loans and scholarships.

Nowadays, people coming out of medical schools are coming out with loan burdens of up to $100,000, $50,000 to $100,000. These are people who don't have equity, don't have rich parents, and what are they going to do? Are they going to go practice primary care and emergency medicine, or are they going to protect themselves and go into a professional direction that can give them more money and more security?

We have some very substantial societal issues that are driving doctors away from emergency rooms, that are driving doctors away from working in communities. It is not a willful attitudinal issue on the part of doctors; it is something much more deeply rooted in society.

Mr. RANGEL. Well, Doctor, in order for us to be helpful, you are going to have to direct us to where we can bring the people together so that politically we can share with them the fact that they are not going to get all the support that they traditionally have given if they don't respond to the needs that we have today, and the problem that we have, especially among doctors and lawyers; preachers don't have this problem too much.

Mr. FAUNTROY. Oh, no, that is right.

Mr. RANGEL. Is there a refusal to critique their own colleagues or to come up with ideas as to how, as a profession, they could better serve? I am just amazed at the number of minority doctors who have gone to school under Federal programs, but don't want to fulfill their contractual obligations because they would like to join their more affluent classmates in specialization.

But we do have a national crisis, and I think that these hearings have helped to prove that it is not an inner-city problem that we are talking about. We are talking about a national problem that is going to take national solutions so that when we meet with the American Medical Association, with their long list and their very, very able political machinery, that if we don't see this on their list or the American Hospital Association, we will have to bring those teams together.

Let me ask this, which is directly related, why is it that I get the feeling that as it relates to rehabilitation, that I don't find the doctors' leadership in this as much as one might suspect?

Now, I quoted Dr. Richardson. We all are familiar that there is socioeconomic problems and lack of education and homelessness and joblessness and a variety of other things, but I get so sick and tired of having to be impressed by an ex-addict as being the director, the administrator, the therapist, the professional, and with the exception of the methadone programs, which has been the subject by itself of several hearings, I just don't see the doctor. I don't think I see the doctor.

Dr. CARRILLO. Again, I think, this is in part related to the culture of the medical schools, what people are oriented towards. When you come into medical school you have your role models up there talking to you. You have them teaching you.

It is like any other situation, and you are taught that to be smart, to be successful, you have to be this kind of a specialist, this kind of a surgeon, this kind of a thing, and things like primary care, rehabilitation care, chronic care, emergency care are neglected. We had in New York City a massive fight with New York University around setting up an emergency medicine teaching program at Belleview.

It is only now that Dr. Richardson is leading, at Harlem Hospital, in setting up an emergency medicine teaching program, so it is very much a part of medical schools not really emphasizing what society needs, and I will be very happy to help with all my energies to help you and other fellow Congressmen in this regard.

Mr. RANGEL. Why can't we do this? You have committed yourselves to the return of the Harlem Hospital School of Nursing. Why don't you allow us to use this to bring in the rest of the teaching schools in New York to see whether they can bring in that support of service to serve as a pilot project to provide health care professionals to the industry where we can have Columbia and City College and NYU to bring in the deans of their schools so that they can hear firsthand as to what should be in these teaching schools around the Nation, and maybe out of that, I am convinced that the Secretary of Health and Human Services will be there, as he has been to New York City, as he has been to Harlem Hospital, so that maybe we can just anchor the direction in which we want to go with the nursing school.

Dr. CARRILLO. We want to make Harlem Hospital a model, a national model of urban care and a cornerstone of that model will be the redevelopment of a nursing school with close linkages with the City University of New York and also the schools, the high schools and junior high schools that we can begin to track children through the junior high, through the high school by having them visit the hospitals, having them take a ride in the ambulance, having the doctors and nurses visit them in the junior high and get them going and make that nursing school the cornerstone of our model.

Mr. RANGEL. Well, let me promise you the financial support of the private sector that I have talked with about this, and they, too, want to come forward to make certain that the leadership that you are providing, that not only does it work but that it excels to encourage other people for doing the same thing.

Rather than investing all of that money just in recruitment, we will invest it in people that will have the opportunity to produce and, Dr. Richardson, what a great opportunity for you to be able to share firsthand what Mike's offering, the partnership that is being opened because as the city university system picks up a part of this, my God, we wouldn't want our doctors to be so far behind, and it is just the greatest marriage, and I will petition the national associations in a very partisan way to support this so that we can have pilot projects like this throughout the Nation because if you wait for this Government to provide the leadership with all of your legislative leaders on all military Air Force Base and the President is running around and the country beating up on the Congress, clearly this is not inspiration for sick people to wait for before they get well, but if we go out and build a political force that is stronger than the addict, the aged, and the sick, which will have our doctors, our administrators, our national organizations say, we are here to teach you how to save money and reduce the deficit, I promise that we can get their attention.

This has been a great hearing, and we want you on the front lines to know that you are really not forgotten, you are really there in the trenches. It is what MASH is all about on television, you are living it on a day-to-day basis, and we have in the crime bill, I am ashamed to say, a $50 million minipackage from the trauma bill that was drafted by my colleague, Congressman Waxman, but at least it shows that the Congress is aware of the problem and together I am confident that we will get enough people on this committee and off of this committee to be working with you as one force to turn this around, so let me thank you very much for the contribution that you make on a day-to-day basis and especially in front of this committee.

Would you like to——

Mr. FAUNTROY. Thank you, Mr. Chairman, no.

Mr. RANGEL. Thanks again.

This committee stands adjourned.

Mr. CHASTANG. Thank you very much.

Dr. REISNER. Thank you.

Dr. CARRILLO. Thank you.

[Whereupon, at 12:40 p.m., the select committee adjourned.]

PREPARED STATEMENTS

OPENING STATEMENT

GOOD MORNING LADIES AND GENTLEMEN.

I AM CHARLES RANGEL, CHAIRMAN OF THE HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL. WELCOME TO THE 20TH ANNUAL CONGRESSIONAL BLACK CAUCUS WEEKEND.

ONE OF MY FUNCTIONS AS A MEMBER OF THE CAUCUS IS TO SERVE AS CHAIRMAN OF THE NARCOTICS BRAINTRUST. IN THIS ROLE, TODAY I AM SPONSORING A HEARING ON THE "THE EMERGENCY ROOM CRISIS: THE IMPACT OF DRUG ABUSE."

SEVERAL YEARS AGO WHEN WE WERE DEALING WITH THE START OF THE CRACK COCAINE CRISIS, EXPERTS TOLD US THAT THIS WOULD ONE DAY EXTEND ITS REACH TO THE DOOR STEPS OF OUR HOSPITALS AND EMERGENCY CARE CENTERS, AND IT HAS. IN EMERGENCY ROOMS, IN MANY OF OUR INNER CITY COMMUNITIES ACROSS THE COUNTRY, DOCTORS AND NURSES AND OTHER HOSPITAL STAFF ARE STRETCHED TO THE LIMIT TO ACCOMMODATE A GROWING NUMBER OF GUNSHOT AND OVERDOSE VICTIMS. THESE VICTIMS OF TODAY'S DRUG CRISIS ARE SQUEEZING OUT THE QUALITY AND IMMEDIACY OF CARE AVAILABLE TO THE TRADITIONAL EMERGENCY ROOM PATIENT.

MANY OF US KNOW THE THREAT THAT WE FACE EVERY DAY FROM THE DRUG CRISIS. WE DON'T HAVE TO BE USERS OR SELLERS TO BE AFFECTED BY THE VIOLENCE SPAWNED BY THE DRUG TRADE. WE DON'T HAVE TO BE USERS OR SELLERS TO PAY A GROWING SHARE OF OUR HARD-EARNED DOLLARS TO BUILDING AND MAINTAINING AN ELABORATE NETWORK OF PRISONS TO HOUSE DRUG LAW VIOLATORS. AND NOW, WE DON'T HAVE TO BE USERS OR SELLERS OF DRUGS TO BE VICTIMIZED IN OUR VERY OWN HOSPITALS. IMAGINE HAVING A RELATIVE IN NEED OF ATTENTION FOR A BROKEN BONE, OR, GOD FORBID, A HEART ATTACK OR A STROKE, BUT HAVING TO COMPETE FOR SERVICES WITH SOMEONE SHOT IN A DRUG DEAL GONE SOUR OR WITH SOMEONE WHO HAS GONE INTO A COCAINE INDUCED COMA.

THE WITNESSES WE HAVE SCHEDULED FOR TODAY ARE:

- DR. J. EMILIO CARRILLO, PRESIDENT, NEW YORK CITY HEALTH AND HOSPITALS CORP.
- DR. LYNN RICHARDSON, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS. SHE IS AN OFFICIAL WITH HARLEM HOSPITAL.
- MARK CHASTANG, EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL
- DR. MICHELLE REISNER, DIRECTOR OF EMERGENCY SERVICES, JERSEY CITY MEDICAL CENTER, JERSEY CITY, NEW JERSEY
- DR. ARTHUR KELLERMAN, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS ALSO DIRECTOR OF EMERGENCY MEDICINE, REGIONAL MEDICAL CENTER, MEMPHIS, TENNESSEE

EVEN WITHOUT THE DRUG CRISIS, THE FUTURE OF OUR EMERGENCY HEALTH CARE SYSTEM IS ALREADY BEING STRAINED BY THE INCREASING COST OF TRAUMA CARE AND BY A GROWING NUMBER OF TRAUMA PATIENTS WHO HAVE NON OR INADEQUATE HEALTH COVERAGE.

IT HAS BEEN REPORTED THAT UNCOMPENSATED HEALTH CARE GREW FROM $3 BILLION TO $8.3 BILLION BETWEEN 1980 AND 1988. THE POTENTIAL IS THERE FOR THIS FIGURE TO GO EVEN HIGHER. ALTHOUGH 1989 FIGURES SHOW A DOWNTURN, THE NATIONAL INSTITUTE ON DRUG ABUSE REPORTS A FIVEFOLD INCREASE IN DRUG-RELATED MEDICAL EMERGENCIES FROM 1984 THROUGH 1988. THE NUMBER OF HOSPITAL EMERGENCY ADMISSIONS WITH COCAINE AS A MENTION REACHED 46,020 IN 1988, COMPARED WITH 8,831 IN 1984.

SOME EXPERTS HAVE PREDICTED THAT BY THE YEAR 2000, SOME 40 PERCENT OF THE NATION'S 2,000 ACUTE CARE FACILITIES WILL BE CLOSED.

TODAY I HOPE THAT WE WILL BE ABLE TO ENGAGE IN A PRODUCTIVE, FRUITFUL DIALOGUE THAT WILL GET THE BALL ROLLING, AND GET OUR CREATIVE JUICES FLOWING SO THAT OUR GOVERNMENT CAN RESPOND PROPERLY AND EFFICIENTLY TO THIS GROWING HEALTH CARE CRISIS.

I LOOK FORWARD TO THE TESTIMONY OF EACH OF OUR WITNESSES.

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OUR HOSPITALS ARE TOO PRECIOUS OF A RESOURCE; OUR DOCTORS, OUR NURSES AND OUR OTHER MEDICAL PERSONNEL ARE TOO TALENTED; OUR NEED FOR THE AVAILABILITY OF IMMEDIATE MEDICAL ATTENTION FOR OUR MOST CRITICALLY ILL AND INJURED IS TOO GREAT TO ALLOW THE EROSION OF THESE SERVICES AND PERSONNEL, WHETHER FROM A BURGEONING DRUG-RELATED CASELOAD, OR FROM SOME OTHER SOCIAL CATASTROPHE.

THANK YOU.

N A P H

Testimony of

Arthur L. Kellermann, M.D., M.P.H.
Director, Emergency Department
Regional Medical Center at Memphis

Before the Select Committee on Narcotics Abuse and Control

On behalf of

Regional Medical Center at Memphis

and the

National Association of Public Hospitals

September 28, 1990

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS • 1212 NEW YORK AVENUE, NW • SUITE 800 • WASH., DC 20005 • (202) 408-0223 • FAX (202) 408-0235

I. INTRODUCTION

Mr. Chairman, I am Dr. Arthur Kellermann, Director of the Emergency Department of the Regional Medical Center at Memphis, the safety net hospital for Memphis and Shelby County, Tennessee. I am also Chief of the Division of Emergency Medicine at the University of Tennessee. I speak today on behalf of the National Association of Public Hospitals and the millions of patients who receive care in American emergency departments this year. NAPH consists of approximately 90 public and non-profit hospitals that serve as major referral centers, teaching hospitals, and hospitals of last resort -- "safety-net hospitals" -- for the poor in most of our nation's largest metropolitan areas. NAPH member hospitals provide a significantly higher volume of inpatient and outpatient services than their private sector counterparts; they provide many unprofitable specialized services; they are extremely dependent upon governmental sources of revenue (local, state and federal), and typically, have a much lower proportion of privately insured patients.

In 1989, total emergency visits to The Regional Medical Center at Memphis exceeded 98,000. Five thousand of these patients were received and treated in our level 1 trauma center, 22,000 were visits made by women in advance stages of pregnancy and the remaining 70,000 were adults with general medical, surgical or psychiatric emergencies treated in my emergency department.

II. EMERGENCY DEPARTMENT OVERCROWDING

Once evaluated and stabilized, many of my Emergency Department (ED) patients treated must be held in the ED for variable periods of time because no vacant ward or ICU beds are available. Stays of 12 hours or longer are commonplace and stays of 24 hours or longer are not unusual. In my emergency department, privacy is nonexistent, bedpans serve as restrooms, visits are severely limited and meals arrive cold. When overcrowding is severe, my staff physicians have been known to intubate drug overdose patients, pump their stomachs, wean them off the respirator and eventually discharge them without the patient ever seeing an inpatient bed. It is not that we don't care, but when our hospital is full, we have little choice but to ration the meager supply of hospital beds available so that only the sickest emergency patients eventually receive inpatient care. Every day I send patients home that I would rather keep in the hospital. Every day, I badger my inpatient colleagues to discharge patients before they are ready to leave. When overcrowding reaches the point that we cannot care for additional ED patients safely, we have no choice but to try to divert incoming ambulances to neighboring private hospitals. Born in desperation, ambulance diversion can compromise a community's emergency medical service system by requiring ambulances to transport patients far outside their normal call areas. This rarely accomplishes much, since many private community hospitals are almost as overcrowded as we are. In fact in the past three months, five private hospitals in Memphis requested ambulance diversion at one point in time or another.

III. DRUGS AND OVERCROWDING

Mr. Chairman, I hope today to convince the members of your committee and your colleagues in Congress of three fundamental facts about hospital and emergency department overcrowding.

1. Overcrowding is not limited to New York City hospitals or institutions in the Northeast corridor.

2. Overcrowding is no longer limited to public hospitals which care for the poor and the uninsured. Many of our nations premier private teaching hospitals are experiencing problems every bit as severe as those confronting our nation's public hospitals.

3. Although our national pandemic of drug abuse, drug related violence and drug related health problems is a major contributor to the steadily growing demand for emergency care in the United States, drugs are only <u>one</u> of a number of factors that are combining to threaten the fundamental nature of our nation's emergency care system.

This last observation should not be construed to mean that I do not consider drugs and drug abuse to be a problem for my hospital. In the first six months of 1990 alone, 38 percent of expectant mothers screened at the Regional Medical Center at Memphis acknowledged or tested positive for cocaine and/or other drugs. More than 17 percent were still actively using drugs at the time of their delivery. 261 babies in our newborn center were born to drug addicted mothers. The director of our trauma center estimates that 20 percent of his monthly admissions are victims of drug related violence or trauma sustained as a result of drug intoxication. In my ED, overdose patients with <u>direct</u> effects of cocaine and/or drug toxicity account for between 40 and 60 medical and/or psychiatric emergencies each week. However, this total represents less than five percent of our weekly total of visits. Comparable figures to these have also been collected at other NAPH member institutions. Statistics such as these illustrate the difficulty of interpreting drug related surveillance data from hospital emergency departments. Many ED charts (the source of data for D.A.W.N. and other surveillance systems) often omit "mentions" of drugs when the case involves trauma or other <u>indirect</u> complications of drug abuse. In most hospitals, cases of this type account for far more drug related emergencies than"overdose" cases alone.

IV. CAUSES OF ED OVERCROWDING

Although the demand created by drug abuse on America's emergency department is profound, drugs are only one of several factors that have contributed to the problem of hospital and ED overcrowding nationwide.

In 1980, no one could have predicted the staggering impact that AIDS would have

on our nation's acute care hospitals. Few believed that our patchwork quilt of health care programs for the poor, elderly and uninsured would fray so quickly, or that millions of additional patients would come to utilize emergency departments as their sole source of medical care. Ironically, during a decade of increasing demand, the federal government and many states compounded these problems by cutting back financial support to hospitals and by mandating bed reductions. Efforts to foster "health care competition" worsened things further by encouraging hospitals to convert medical/surgical beds to more lucrative pursuits (such as alcohol and drug treatment units). Many hospitals even chose to opt out of the business of providing trauma care entirely, and some have gone so far as to close their emergency departments. In addition to these problems, growing career opportunities for women, long hours and low salaries relative to comparably challenging jobs aggravated an already severe shortage of practicing nurses. In virtually every city entire hospital floors and intensive care units lie vacant because hospitals cannot recruit enough nurses to staff them.

V. THE NATIONAL SCOPE OF THE PROBLEM

In the fall of 1988, the National Public Health and Hospital Institute (NPHHI) joined forces with the University of Tennessee to conduct a survey of the member institutions of the National Association of Public Hospitals and the Council of Teaching Hospitals. Collectively, these two organizations represent virtually all of our nations leading public and private teaching hospitals. A total of 277 institutions responded to our survey, a response rate of 60 percent. Three out of every five respondents are private hospitals. The remaining 40 percent are public institutions. Almost all of these hospitals support major programs in medical education and research. 86 percent are affiliated with certified schools of medicine or osteopathy.

Among responding institutions, 38 percent reported that overcrowding periodically requires them to hold admitted emergency patients 12 or more hours beyond the time normally required for their initial assessment and hospitalization. More than one in four sometimes hold admitted patients in their emergency department for 24 hours or longer. Although few EDs are staffed or equipped to provide ongoing critical care, 27 percent of the hospitals that responded to our survey reported that they sometimes have to hold admitted intensive care unit patients in their ED for 12 or more hours beyond the time normally required for stabilization due to lack of vacant ICU beds. 19 percent periodically hold ICU patients in their EDs for 24 hours or longer. During a single reference month (August 1989), 30 percent of responding hospitals refused interhospital transfers due to overcrowding at least once, one third transferred patients to other institutions and 40 percent diverted selected ambulance patients (such as critical care cases) at least once during the month. 22 percent diverted all incoming ambulances at least once during the month. Of note, private teaching hospitals reported rates of overcrowding comparable to those reported by the public hospitals that responded to this survey. Despite such measures, the costs of ED overcrowding appears to be high; 60 percent of the public and private hospital ED directors who responded to this survey believe that overcrowding is having a moderate to severe adverse impact on their quality of care.

Sufficient data were also available for us to compare the severity of overcrowding at public and private teaching hospitals in eight major U.S. cities: Chicago, Detroit, Los Angeles, New York, Philadelphia, San Francisco, St. Louis and Washington, D.C. By almost every measure, the magnitude of the crisis in New York is more severe than any other city in the country, but major problems were also noted in Los Angeles, Detroit, Philadelphia and the District of Columbia. It is also important to remember that our study is based on data collected in 1988. In many of the cities and elsewhere, the problem is worse now than it was then.

VI. POTENTIAL MEASURES TO DEAL WITH OVERCROWDING

Immediate steps need to be taken to begin to correct the imbalance of supply and demand as it relates to the provision of emergency treatment and acute inpatient care. NAPH supports the recent recommendations of the American College of Emergency Physicians task force on hospital and ED overcrowding. These include the following.

1. Remove financial disincentives for providing emergency care. Current prospective payment mechanisms often fail to adjust for the fact that emergency patients are sicker, need more tests, cost more to treat and require longer hospitals stays than elective patients admitted with the same diagnosis. As a result, institutions conscious of the bottom line have a strong incentive to favor elective admissions over emergency patients. Under current rules, hospitals which operate trauma centers or admit a large percentage of their patients through the ED pay a particularly stiff price for their commitment to emergency care.

2. Where needed, increase the system's capacity to provide critical care, inpatient treatment and nursing home services. In some cities, small community hospitals may have high vacancy rates while regional centers and public hospitals are seriously overloaded. Current criteria for awarding hospitals "certificates of need" may need to be revised. Also, large numbers of inpatient, acute care beds are getting tied up with patients who have long since been stabilized and could readily be treated in less expensive nursing homes, hospices and other sources of "alternative care" if such beds were more available. System capacity must be allocated more appropriately to meet current demand.

3. Expand the supply of nurses. Nurses are the backbone of health care in this country and the demand for nurses (specially those who provide inpatient and critical care) far exceeds supply. The federal government and the states need to support initiatives to train more nurses (through nurse scholarships and grants-in-aid) and support efforts to relieve nurses of the crushing burden of paperwork. Also, nurses must be paid more. Along with teachers, nurses are the most underpaid professionals in America.

4. Support access to primary care services and support state initiatives to prevent illnesses and serious injuries. Although utilization of emergency departments for non-emergency problems clogs waiting rooms, it does not cause ED overcrowding. However, better access to primary and preventive care services can prevent many illnesses from reaching the point where expensive emergency department care of hospitalization is necessary. Each year, trauma kills 142,000 Americans, permanently disables 80,000 more and costs society $44 billion in direct health care costs. If the federal government required all states to adopt mandatory seatbelt and motorcycle helmet laws, lower speed limits to 55 and directed more funds to support research and pilot programs to prevent injuries, we could save more lives, prevent countless serious injuries, decrease costly hospital stays and save billions of dollars in health care costs annually.

5. Provide a basic level of health insurance for all citizens. Emergency departments are the only entities mandated by federal law to provide care to all who need it. For many in this country, emergency departments are their only source of health care. Half of the patients who present themselves to the triage desk of my ED have no usual source of care or identify my emergency department as their "family physician". Of the 70,000 patients treated in my emergency department each year, only 8 percent have private insurance. Medicare covers 10 percent and 24 percent have Medicaid. The remaining 58 percent are uninsured. The American College of Emergency Physicians estimates that nationally, 31 percent of the care provided by emergency physicians nationwide is uncompensated. Throughout the 1980's, the proportion of care provided by NAPH hospitals that is uncompensated has climbed steadily. By 1988, 29 percent of all inpatient days at NAPH hospitals and 52 percent of all outpatient visits were uncompensated. This level of uncompensated care cannot be sustained indefinitely. Every one in this country should be able to gain access to al least a decent minimum of acute and preventive health care.

VII. CONCLUSION

Hospital and emergency department overcrowding is real. It cannot be ignored, wished away, or left off our master list of national priorities. When a major injury occurs or serious illness strikes, everyone wants (and expects) to receive top quality emergency care. Unfortunately, as our nation's emergency departments and trauma centers fill to capacity, no one can safely assume that they will get timely access to emergency care when they need it, regardless of their wealth, insurance coverage or political connections.

The alternative to tackling this problem is to do nothing, a tempting strategy as Gramm Rudman looms before us. Public hospitals cannot continue to absorb massive financial shortfalls without dire consequences. Some of you may be tempted to "fix" this problem by passing rules or regulations to forbid us "holding" sick and injured patients

in our emergency departments under penalty of law. When our hospitals are full, and no alternatives are available, such rules will have the same effect as a law ordering me to save shoe leather by walking four feet off the ground. It simply can't be done. Emergency physicians, nurses and the hospitals in which we work are committed to providing the care our patients need, but we must have the facilities, and the means to accomplish the task.

STATEMENT

of the

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

to the

Select Committee on Narcotics Abuse and Control

U.S. House of Representatives

Presented by

Lynn Richardson, MD, FACEP

Associate Chief, Emergency Services
Harlem Hospital

RE: Emergency Department Overcrowding

September 28, 1990

Mr. Chairman, I am Dr. Lynn Richardson, Associate Chief of Emergency Services for Harlem Hospital Center in New York City. I am pleased to appear today representing the American College of Emergency Physicians (ACEP) to discuss emergency department (ED) overcrowding. ACEP is a medical specialty society representing over 14,000 emergency physicians across the country. I am accompanied today by Stephanie Kennan of our legislative staff.

THE SCOPE OF EMERGENCY DEPARTMENT OVERCROWDING

Emergency Department overcrowding is a serious symptom of the ills of our nation's health care system. Simply described, ED overcrowding is the holding of patients in the ED because of a variety of factors. These are patients that have been examined and evaluated and have health problems that need to be addressed. The factors causing overcrowding include a lack of available inpatient resources, a shortage of personnel, the unavailability of alternative primary care services, and the presence of a large number of uninsured. It is not just a "New York" problem or just an urban problem. ED overcrowding seriously affects the ability of each individual to receive timely, quality emergency care regardless of insurance status or where they live.

In 1989, ACEP conducted a survey of its 54 chapters to help assess the extent of emergency department overcrowding, which had initially been reported in New York, Boston, and Los Angeles. Our chapter survey showed that 41 states reported overcrowding problems. A summary of the survey is attached.

Earlier this year, Dennis Andrulis of the National Public Health and Hospital Institute and one of my colleagues, Dr. Arthur Kellermann, Medical Director of the Regional Medical Center in Memphis, Tennessee, presented results of a 1988 survey of the nation's major public and private teaching hospitals. Among the 277 institutions who responded to their survey, 38 percent reported that overcrowding sometimes required them to hold admitted patients in their EDs 12 or more hours beyond the time normally required for emergency hospitalization.

Over one-fourth of the institutions acknowledged that they sometimes have to "hold" admitted patients in the ED for 24 hours or longer. Forty percent acknowledged periodically diverting ambulances to other hospitals due to overcrowding. Perhaps surprisingly, the situation in private teaching hospitals was reported to be no better than the problem reported in public teaching hospitals.

At my hospital we have had as many as 25 patients holding in the ED. We also have had patients whose entire hospital stay is in the ED.

A variety of factors contribute to this health care crisis. No one could have predicted the crushing burden that AIDS, drug abuse, and violence would place on our hospitals. These problems coupled with a shortage of nurses, emergency physicians, appropriate inpatient resources, and federal and state funding cutbacks have frayed our fragile health care system.

THE ROLE OF THE EMERGENCY PHYSICIAN

Emergency physicians meet the need for prompt treatment of patients with emergencies regardless of a patient's ability to pay. ACEP believes that quality emergency care is a fundamental individual right and should be available to all who seek it. In addition, emergency departments often serve as the entryway to the entire health system for uninsured or underinsured patients, because alternative treatment sites may be in short supply or unavailable in the community. Thus, like every emergency department across the country, my ED is frequently the provider of last resort, providing access to health care for those without public or private health insurance protection.

No other physician is available 24 hours a day for unscheduled care. A 1984-85 survey conducted by the National Opinion Research Center for the Health Care Financing Administration found that uninsured patients accounted for 19 percent of the visits to emergency physicians. Another survey conducted by Mathematica Policy Research, Inc., for ACEP in 1986 found that on average, 31 percent of the care provided by emergency physicians was uncompensated care.

This year ACEP projects that there will be 90 million visits to emergency departments nationwide. If one-third of this care is uncompensated, we are stretching the safety net of the emergency department and asking emergency physicians to do more and more with less and less.

From a hospital's point of view, emergency department's could be viewed as a financial drain. As the overcrowding crisis occurs more often, requiring more resources be placed

in the emergency department, it may become financially impossible for a hospital to maintain quality emergency care. This is particularly true as more hospitals face limitations on available financial resources.

State and federal policy requirements imposed on emergency departments have increased the responsibilities of emergency physicians and emergency departments to fill gaps in the health services delivery system. In 1986, Congress required that every patient presenting with complaints to a hospital emergency department be given an appropriate screening examination. The goal of a screening examination is to determine whether the individual has an emergency medical condition or is in active labor. The law further requires that patients found to have emergency medical conditions or be in active labor must be provided necessary medical treatment within the hospital's capability to stabilize their condition.

Therefore, emergency departments are the only entities mandated by federal law to provide care to all who need it, regardless of ability to pay. Congress must understand that as emergency physicians, we are very concerned about our ability to provide needed medical services to the patients who come to our door requiring care, particularly as the factors contributing to overcrowding continue to grow.

THE IMPACT OF OVERCROWDING

Let me give you an example of the typical patient load I see upon coming to work each day.

There is Mrs. Johnson who is a 49 year old woman who works in a library. She had been having chest pain for several days and finally her co-workers convinced her to come to the emergency department. Unfortunately, we had to confirm her worse fears -- it is her heart. She was given medicine to control her pain and we now must monitor her heart rhythm continuously. She should be resting in a calm quiet room upstairs in the hospital. Instead, her care for the last 23 hours has been in my emergency department because no appropriate bed was available.

Across from Mrs. Johnson is a 67 year old woman who had a massive stroke. We had to put her on a respirator because she was not breathing well on her own. She has been in the emergency department for 19 hours waiting for a bed in the intensive care unit.

On one side of Mrs. Johnson is a young cocaine addict who was brought to the emergency department with seizures. He had four generalized convulsions before we got them under control. The stretchers were so close together that each time he seized, the staff would have to move Mrs. Johnson to be able to attend the addict's seizure.

On the other side of Mrs. Johnson is a 17 year old who tried to kill herself with an overdose of pills. She was given a medication to empty her stomach and spent the last hour retching into a basin.

On this particular morning that I am describing to you, there are 13 patients in my ED, most of them on stretchers in the hallway waiting for additional care. Hour after hour, sometimes day after day, they must experience their illness lying on a stretcher that was never meant to be used as a bed, with no privacy in an area that was not meant to provide on-going continuous care.

In the ED, patient amenities such as hot meals, telephones, visitation rights and privacy are few or nonexistent. EDs were not designed and are not staffed to provide the on-going care that critically injured or ill patients require.

When overcrowding reaches crisis levels, diversion of ambulances to neighboring hospitals simply spreads the problem throughout the city, as patients find themselves taken to hospitals where they have never before received care and where their personal doctor, if they have one, lacks admitting privileges.

Under severe circumstances, multiple hospitals can "close" their EDs simultaneously. This can lead to emergency medical services gridlock as ambulances literally circle the city looking for a place to take their patients. Let me remind you that when overcrowding is severe, no one, regardless of their wealth, power, or prestige can be guaranteed timely access to effective emergency care.

OVERCROWDING AND DRUG ABUSE

While overcrowding is not caused by the drug epidemic alone, drug abuse in one way or another is the major cause of the types of cases I treat. Many of the patients I treat would not have a diagnosis that would necessarily be correlated into the statistics specifically related to drugs. However, the elderly woman I treat for a hip fracture because she was pushed down in a robbery attempt by junkies or the 29 year old pregnant woman caught in gun-fire of dealers having a turf fight are victims of drug abuse as well.

In addition, the crack epidemic has brought about an increase in the type of cardiac problems I see in young children. These, too, are victims of drug abuse that may not appear in the statistics related to drugs.

As crack replaces heroin as the drug of choice in many areas, emergency physicians are treating different kinds and in some ways more serious types of injuries. When under the influence of crack, an individual looses the ability control impulses. Thus, an increase in violent crime and interpersonal violence occurs. With crack, guns have been introduced at every level. It is not uncommon for me to treat teen-agers over and over again for gun shot wounds, until one day their luck runs out. Virtually all the crack addicts that I treat have weapons. Most heroin addicts did not carry weapons.

Sadly, almost all the AIDS patients I treat are IV drug abusers. They have no other place to receive care except the ED. Additionally, I treat many pneumonia and cardiac cases that result from drug abuse.

As I have stated, no one could have predicted the burden these societal problems would place on the health care system. Yet, we are now at a point where the health care of every individual is at risk.

MANPOWER SHORTAGE

The Graduate Medical Education Advisory Committee (GMENAC) report of 1980 predicated a shortage of emergency physicians by 1990. By examining the total number of emergency departments and current staffing patterns, an accurate projection of the supply of emergency physicians needed to meet the demand can be developed. According to the American Hospital Association (AHA) there were 5,600 hospitals in 1985 with EDs. A recent ACEP staffing pattern study showed 4.7 full-time equivalents per ED. Based on these figures, there is a need for as many as 26,320 full-time equivalents in emergency medicine. There curently are approximately 9,000 board certified emergency physicians and 16,000 other physicians practicing both full and part time in emergency departments.

Currently there are 83 emergency medicine training programs producing approximately 550 graduates per year. The American Medical Association projects that the normal attrition rate for specialists is two to three percent or nearly 700 physicians per year. Because of the stress associated with emergency medicine, ACEP believes the two to three percent figure is low for our specialty. The demand for the services of emergency physicians will continue to increase in the future. According to AHA data, from 1973 to 1986 ED visits grew 24.7 percent. Obviously if we loose more emergency physicians than we produce per year, we will not be able to assure the delivery of quality emergency care.

Of the 50 nurse staffing positions in my ED, only 22 are currently filled. The hospital uses substitute nurses to supplement the staff, but the nurses work short staffed every day.

Only 60 percent of the emergency physician shifts in my department are filled by career emergency physicians although they are not all board certified or board prepared. We try to fill the rest of the positions with physicians from other specialties. We work short staffed about 25 percent of the time.

SOLUTIONS

Solving the drug abuse problem alone would not solve the ED overcrowding crisis. For the youngsters I treat for gun-shot wounds who are caught up in the culture of the drug world, it is more than just the health care system that has failed them. Our educational system and our ability to teach them that there is some value in their lives has also failed.

The American College of Emergency Physicians also realizes that in these times of severe budget deficits, that to say simply spending money will solve the problem is not productive. However, as a physician I can only speak to the problems facing me as I try to deliver health care to those who come to me. We must continue the guarantee that the emergency department will be there to provide emergency care to all those who require it. For many, the issue is financial resources.

The health problems of the poor and uninsured may contribute a disproportionate share to this problem by accessing the emergency department too late in their illnesses to receive primary care. Often, it is the absence of primary care that is contributing to the increasing severity of illness we are experiencing in the ED.

In order to correct these conditions, ACEP supports the following steps:

-Presumptive eligibility for certain services for the uninsured. This would require amending the Medicaid law to establish presumptive eligibility for unsponsored patients who present to the ED with emergencies.

-Increased appropriations for health education funds and training programs for emergency medicine and expansion of programs of undergraduate nurse education.

-Increased payment for physician evaluation and management services under Medicare and Medicaid.

In addition, ACEP is a member of the Physicians Access to Care Coalition which is composed of over 21 physician organizations working to urge Congress to adopt legislation providing health coverage for all Americans. The Coalition believes that the preferred approach is one that builds upon the strengths of the public/private system of insurance.

To that end, the coalition believes employers should be required to provide health insurance to their employees and dependents with cost-sharing by employees. Recognizing the potential financial burden this could impose on certain small businesses, Congress should include provisions which would ameliorate the impact of this requirement such as tax relief, subsidies, phased-in implementation, risk pools, and other reforms which would make insurance more available and affordable.

In addition, Medicaid should be both expanded and substantially improved including the enactment of minimum eligibility and benefit levels and incentives to enhance provider participation. The current Medicaid program covers fewer than 42 percent of Americans with incomes below 100 percent of the federal poverty level.

The coalition further believes that for those who are not eligible for employer based insurance and who have incomes in excess of the enhanced Medicaid eligibility level, provision should be made for participation in a subsidized program with cost-sharing on a sliding scale premium basis.

The coalition believes that health insurance programs, whether public or private, should provide access to basic physician and mental health benefits.

ACEP believes that any legislation should (1) include emergency care in the minimum benefit package; (2) require emergency care as a core service that must be provided under any plan; and (3) provide reasonable compensation for emergency department services.

Mr. Chairman, we again thank you for the attention you have focused on the problem of ED overcrowding and we look forward to working with you on solutions to the problem.

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HOSPITAL AND EMERGENCY DEPARTMENT OVERCROWDING

In 1989, the American College of Emergency Physicians conducted a survey of its chapters to help assess the extent of emergency department and hospital overcrowding which had initially been reported in New York, Boston and Los Angeles. This survey was designed to give the College a "broad brush" picture of the nationwide pervasiveness of this situation.

The extend of overcrowding, as reported in the survey, exceeded the College's expectations. ACEP chapters in 41 states reported overcrowding problems. In addition to these states, chapters representing Ontario, Puerto Rico, the District of Columbia and military hospitals reported overcrowding.

This initial survey did not attempt to gather specifics regarding how many emergency departments are experiencing this problem. It asked chapters whether overcrowding exists and to identify contributing factors. The survey has allowed the College to establish a network of emergency physicians across the country who face overcrowding in their emergency departments. ACEP will use this network to gather more details and enhance the initial report prepared by the College's Task Force on Hospital and Emergency Department Overcrowding.

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Earl E. Smith III MD FACEP

Ellen H. Taviaferro MD FACEP
Robert M. Williams MD FACEP
Charlotte S. Yeh MD FACEP

Michael J. Breslin MD FACEP *Speaker*
Dennis C. Whitehead MD FACEP *Vice-Speaker*

Colin C. Rorrie Jr. PhD *Executive Director*

Attachment A

American College of Emergency Physicians

1989 CHAPTER SURVEY ON HOSPITAL AND EMERGENCY DEPARTMENT OVERCROWDING

- States reporting overcrowding problems: 41

- States reporting no overcrowding problems: 9

Idaho	*New Hampshire*	*Oregon*
Minnesota	*New Mexico*	*Utah*
Nebraska	*North Dakota*	*Wyoming*

- Contributing factors:
  1. Shortage of health professionals (primarily nurses)
  2. Increased use of emergency departments for hospital admissions
  3. High inpatient average daily census
  4. More poor/uninsured patients
  5. Hospital bed reductions
  6. Emergency department standby/diversion status
  7. Shortage of nursing home beds/home care
  8. Hospital closures
  9. Emergency department closures
  10. AIDS patients
  11. High average length of hospital stay

Attachment B

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

EMERGENCY NURSES ASSOCIATION

Position Statement: Jointly Approved September 1989

HOSPITAL AND EMERGENCY DEPARTMENT OVERCROWDING

Many Americans face a crisis in health care that is widespread and growing. Hospital overcrowding, and the resultant congestion and holding of patients that occurs in emergency departments in many parts of the country, is severely limiting the public's right to timely access to emergency medical care and the quality of that care.

There are numerous factors contributing to the problem of emergency department overload, including a shortage of health care professionals, especially nurses, increased numbers of poor and/or uninsured patients, and hospital or emergency department closures. Underlying many of these factors is inadequate funding for health care services during a period of increasing demand. The emergency department is generally the first area compromised when hospitals do not have an adequate number of beds for patients requiring hospital admission, because such patients remain in the emergency department.

Therefore, emergency physicians and nurses are called on to provide ongoing inpatient and intensive care (ICU) services in the emergency department, in addition to their responsibilities to other emergency patients. Thus, their capacity to provide safe and efficient medical and nursing care, is at best, limited. With increasing frequency, the overburdened resources of crowded emergency departments have forced staff to delay basic emergency care to sick and injured individuals. In some

areas, the health care system has become so overcrowded that there are prolonged delays for prehospital providers to find available emergency departments for ambulance patients. These delays further decrease the availability of emergency medical services (EMS) vehicles and manpower, and therefore lengthen EMS response times. In the interest of every citizen of this nation, this trend cannot be allowed to continue.

Emergency physicians and nurses cannot by themselves control the factors that impair the availability , timeliness, and quality of the emergency care they provide. While they are working with their colleagues to improve the efficiency of hospital admission and discharge procedures, to facilitate communication between hospitals and prehospital providers regarding hospital and emergency department bed availability, and to standardize policies that regulate regional emergency department availability and ambulance diversions, these are only stopgap measures; long-term solutions are urgently needed.

On behalf of our patients, the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA) challenge other health care organizations, allied agencies, lawmakers, and concerned groups or individuals to join in examining both short- and long-term solutions to this problem at both the local and national level, developing recommendations and, most importantly, educating the public regarding the nature and importance of this issue.

ACEP and ENA remain committed to timely access by emergency department patients to necessary emergency and inpatient hospital care.

TESTIMONY BY

J. EMILIO CARRILLO, M.D., MPH

PRESIDENT

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

DRUG ABUSE AND ITS IMPACT ON THE HEALTH CARE SYSTEM OF NEW YORK CITY

SEPTEMBER 28, 1990

GOOD MORNING. I AM DR. J. EMILIO CARRILLO, PRESIDENT OF THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION. WITH ME TODAY IS DR. DOOLEY WORTH, MY SENIOR HEALTH ADVISOR. MR. CHAIRMAN, COMMITTEE MEMBERS, THANK YOU FOR THE OPPORTUNITY TO TESTIFY TODAY ON THE IMPACT OF DRUG ABUSE ON NEW YORK CITY AND ITS HEALTH CARE SYSTEM.

THE MAGNITUDE OF THE DRUG CRISIS, AND THE EXTENT OF OUR NEED TO RESPOND TO IT CANNOT BE UNDERESTIMATED. LAST YEAR, THIS NATION WITNESSED THE RAVAGES OF HURRICANE HUGO. WE SAW PEOPLE WHOSE HOMES WERE DESTROYED, WHO HAD LITTLE FOOD, WHOSE PLACES OF WORK LAY IN RUIN, AND WHO SUFFERED THE PHYSICAL INJURIES OF THE STORM. FEDERAL AID, ALONG WITH SUPPORT FROM COUNTLESS INDIVIDUALS, WAS FORTHCOMING.

WHAT WE FACE IN THIS DRUG EPIDEMIC IS MUCH MORE DEVASTATING THAN HURRICANE HUGO, A ONE-TIME OCCURRENCE. THE DRUG EPIDEMIC IS A CONTINUUM OF DEVASTATION. THE DRUG EPIDEMIC IN NEW YORK CITY HAS LEFT PEOPLE WITHOUT HOMES, WITHOUT WORK, WITHOUT FAMILY SUPPORTS, FACED WITH PHYSICAL AND EMOTIONAL DESPAIR; CHILDREN WITHOUT PARENTS; AND COMMUNITIES IN ECONOMIC RUIN. WHY HAVEN'T WE RESPONDED TO THIS DEVASTATION WITH COMPASSION SIMILAR TO THAT EXTENDED TO COMMUNITIES TOUCHED BY HUGO?

THERE IS A HISTORICAL PREFERENCE FOR CONSIDERING DRUG ABUSE A CRIMINAL PROBLEM RATHER THAN AN ILLNESS AND A PUBLIC HEALTH PROBLEM. THIS HAS RESULTED IN THE LACK OF A LONG TERM COMMITMENT TO TREATMENT RESOURCES AND PREVENTIVE ACTION. FOR YEARS, DRUG ABUSE HAS BEEN THOUGHT OF AS A MORAL ISSUE, AN ISSUE OF PERSONAL FAILURE OF THE WILL, AND AS A VIOLATION OF THE LAW. DRUG ABUSE IS, HOWEVER, A CHRONIC, RELAPSING CONDITION FOR WHICH A CONTINUUM OF DIFFERENT SERVICES IS REQUIRED. DRUG ABUSE IS NOT AN INDIVIDUAL BEHAVIORAL PROBLEM. IT IS A SYMPTOM OF POVERTY, RACISM, SEXISM, INADEQUATE EDUCATION AND LACK OF EMPLOYMENT OPPORTUNITIES, COMBINED WITH THE BREAKDOWN OF TRADITIONAL SOCIAL STRUCTURES IN OUR MOST VULNERABLE COMMUNITIES.

CURRENTLY THERE IS A TREND TO SINGLE OUT SPECIFIC ILLICIT DRUGS FOR TREATMENT, EDUCATION OR INTERDICTION. SUCH APPROACHES FAIL BECAUSE PATTERNS OF DRUG USE ARE DYNAMIC. NEW DERIVATIVES AND COMBINATIONS OF DRUGS COME INTO THE MARKET JUST AS TARGETED PROGRAMS ARE PUT IN PLACE.

BY FOCUSING ON THE IMPACT OF SPECIFIC DRUGS, RATHER THAN THE REASON WHY SO MANY PEOPLE FEEL THEY NEED DRUGS, WE HAVE PURSUED MOSTLY INEFFECTIVE APPROACHES TO RESOLVING THIS EPIDEMIC. WE NEED TO STUDY THE PROCESS OF ADDICTION, THE INFLUENCES WHICH INITIATE, DRIVE AND

SUSTAIN IT. WE NEED TO DEVELOP AND EVALUATE MANY NEW FORMS OF DRUG TREATMENT WHICH ADDRESS THE LONG-TERM COURSE OF DRUG DEPENDENCY. NEW YORK CITY IS AN EPICENTER OF THE DRUG ABUSE EPIDEMIC. THE ONLY HEALTH CARE OPTION FOR MANY ADDICTED INDIVIDUALS IS OUR CITY HOSPITAL SYSTEM, A SYSTEM TRADITIONALLY GEARED TO PROVIDE HIGH TECH, EMERGENCY AND ACUTE CARE. SADLY, WE ARE BETTER EQUIPPED TO HANDLE THE GUNSHOT WOUNDS FROM DRUG-RELATED VIOLENCE THAN WE ARE TO EFFECTIVELY TREAT OR PREVENT DRUG DEPENDENCE TO ASSIST PEOPLE ATTEMPTING TO LESSEN OR STOP THEIR DRUG USE, OR ADDRESS THE IMPACT OF THEIR DRUG DEPENDENCY ON THEIR FAMILIES, PARTICULARLY THEIR CHILDREN. AN ESTIMATED 450,000 CHILDREN IN NEW YORK CITY ARE GROWING UP IN FAMILIES WITH SERIOUS DRUG ABUSE PROBLEMS. RESOURCES THAT CAN AND DO PREVENT HOSPITAL STAYS, AND DIVERT PATIENTS FROM EMERGENCY ROOMS --- COMMUNITY-BASED, PREVENTION-ORIENTED PRIMARY HEALTH CARE AND COMPREHENSIVE DRUG TREATMENT HAVE BEEN NEGLECTED OR POORLY FUNDED.

DRUG ABUSE HAS INUNDATED OUR CITY HOSPITALS. IT IS ESTIMATED THAT NEW YORK CITY HAS 200,000 HEROIN ABUSERS, ABOUT 40% OF THE TOTAL HEROIN ABUSERS IN THIS COUNTRY; AND 20%, OR 400,000, OF ITS COCAINE, CRACK AND OTHER DRUG ABUSERS. DRUG ABUSE IN NEW YORK CITY IS HEAVILY CONCENTRATED AMONG THE YOUNG: ALMOST ONE QUARTER OF THE CITY'S DRUG ABUSERS ARE CHILDREN BETWEEN THE AGES OF 12 AND 17. OUR

EMERGENCY ROOMS SEE YOUNGER AND YOUNGER VICTIMS OF GUNSHOT WOUNDS STEMMING FROM DRUG RELATED VIOLENCE. THEREFORE, NEW YORK CITY ENDURES A MUCH LARGER SHARE OF THE COSTLY PUBLIC HEALTH CONSEQUENCES OF THIS EPIDEMIC: INCREASED VIOLENCE, AIDS, HOMELESSNESS, SERIOUSLY ILL NEWBORNS, OVERCROWDED HOSPITALS AND COMPROMISED HEALTH CARE.

DRUG ABUSE HAS ALSO FUELED AN INCREASE IN THE NUMBER OF PEOPLE COMING TO EMERGENCY ROOMS WITH PSYCHIATRIC PROBLEMS; EMERGENCY ROOMS WHICH ARE ALREADY TREATING A GROWING NUMBER OF HOMELESS PERSONS WITH PROBLEMS RESULTING FROM DRUG ABUSE.

INCREASING NUMBERS OF OUR MEDICAL BEDS ARE FILLED WITH AIDS PATIENTS WHO ARE INTRAVENOUS DRUG USERS OR THEIR SEX PARTNERS. AIDS AND DRUG ABUSE ARE INEXTRICABLY LINKED. AT LEAST ONE-HALF OF THE CITY'S 200,000 IV DRUG ABUSERS ARE HIV POSITIVE, 100,000 INDIVIDUALS. MORE THAN 80% OF THE WOMEN AND CHILDREN WITH AIDS IN NEW YORK CITY ARE INFECTED AS THE RESULT OF INDIRECT OR DIRECT CONTACT WITH INTRAVENOUS DRUG USE. MOST WILL RECEIVE THEIR MEDICAL CARE IN OUR HOSPITALS.

OUR NEONATAL UNITS ARE OVERCROWDED AS A RESULT OF INCREASED MATERNAL DRUG USE. THE COST OF INTENSIVE HOSPITAL CARE FOR EACH

DRUG-EXPOSED BABY IN NEW YORK CITY HAS BEEN ESTIMATED TO BE $90,000. OUR HOSPITALS ARE FILLED TO CAPACITY AT A TIME WHEN THEY FACE NUMEROUS CONSTRAINTS IN THEIR ABILITY TO RESPOND TO AN INCREASED NUMBER OF CLIENTS WHO ARE MORE SERIOUSLY ILL AND CLIENTS WHO HAVE MULTIPLE HEALTH PROBLEMS, INCLUDING ADDICTION. THERE ARE SERIOUS STAFFING SHORTAGES, INADEQUATE REIMBURSEMENT FOR AN INCREASED LEVEL OF CARE, LACK OF PRIMARY CARE AND POST-ACUTE CARE OPTIONS, AND GROSSLY INSUFFICIENT DRUG TREATMENT RESOURCES. AS EMERGENCY ROOMS ARE TRANSFORMED INTO HOLDING AREAS FOR PATIENTS AWAITING ADMISSION, AMBULANCES ARE DIVERTED FROM HOSPITAL TO HOSPITAL.

DESPITE CONCERTED EFFORTS OVER THE LAST THREE YEARS TO STEM THIS DRUG-RELATED "MEDICAL GRIDLOCK", ON ANY GIVEN NIGHT IN NEW YORK CITY, SOME 350 TO 400 PEOPLE WAIT IN HOSPITAL EMERGENCY ROOMS FOR AN INPATIENT BED. THIS MONTH, IN HHC FACILITIES ALONE, SOME 150 PEOPLE COULD BE FOUND AWAITING ADMISSION IN OUR EMERGENCY ROOMS EVERY NIGHT OF THE WEEK.

THE STAFF OF EMERGENCY ROOMS WORK UNDER HIGHLY DEMANDING, EXTREMELY STRESSFUL CONDITIONS, SOMETIMES LIKENED TO WORKING IN A M.A.S.H. UNIT. FOR EXAMPLE, STAFF AT HHC'S HARLEM HOSPITAL CENTER

REPORT THAT THERE IS AN AVERAGE OF TWO GUNSHOT CASES A DAY; IT IS ESTIMATED THAT MORE THAN 90% OF THESE INJURIES ARE DRUG-RELATED. THESE FRIGHTENING STATISTICS ARE SIMILAR TO THOSE REPORTED BY OTHER HHC ACUTE CARE HOSPITALS.

IN ADDITION, EMERGENCY ROOM STAFF REPORT THAT DRUG ABUSE, PARTICULARLY THE INCREASE IN MULTIPLE DRUG USE, COMPLICATES THE TRIAGE PROCESS. IT IS OFTEN DIFFICULT TO DETERMINE WHETHER A PATIENT IS EXPERIENCING A PSYCHIATRIC BREAK OR A DRUG REACTION. DRUG DEPENDENCE AND ITS CONCOMITANT MEDICAL PROBLEMS COMPLICATES TREATMENT DECISIONS, DISCHARGE PLANNING AND POST-ACUTE SERVICES REFERRALS. TREATMENT WHERE DRUG DEPENDENCY IS INVOLVED IS MORE LABOR INTENSIVE AND COSTLY. INCREASED SECURITY COSTS ARE INCURRED AS THE USE OF CRACK AND MULTIPLE DRUGS OFTEN PRODUCE VIOLENT, ERRATIC BEHAVIOR TOWARD THE STAFF AND OTHER PATIENTS.

STAFFING SHORTAGES -- RECOGNIZED NATIONALLY, BUT MORE SEVERE IN NEW YORK CITY, AND MOST INTENSE WITHIN HHC, ARE COMPOUNDED BY THE PROBLEMS OF EMERGENCY ROOM OVERCROWDING. WHILE NURSING SHORTAGES ARE MOST VISIBLE, SIMILAR SHORTAGES EXIST AMONG OTHER HEALTHCARE PROFESSIONALS, PARTICULARLY AMONG STAFF WITH EXPERTISE IN DRUG ABUSE. THERE IS AN URGENT NEED FOR SUBSTANCE ABUSE TRAINING FOR OUR

HOSPITAL PERSONNEL. SUCH TRAINING IS ONE COMPONENT OF APPROPRIATE AND RESPONSIVE DRUG SERVICES FOR THOSE WHO ARE DRUG INVOLVED. DELIVERING THESE SERVICES IS A MAJOR PRIORITY FOR THE CORPORATION. HOWEVER, HHC CANNOT MEET THE COMPLEX NEEDS OF THIS POPULATION ALONE. UNABATED, THE PRESSURES OF THE DRUG EPIDEMIC IN NEW YORK CITY WILL RESULT IN MORE DRASTIC BED SHORTAGES, CONTINUED OVERCROWDING IN OUR EMERGENCY ROOMS, DISPLACEMENT OF PATIENTS TRADITIONALLY SERVED BY HHC AND FURTHER COMPROMISES FOR THE HEALTH CARE OF ALL OF OUR PATIENTS.

THE FEDERAL GOVERNMENT MUST TARGET AND EXPEDITE THE DELIVERY OF ADDITIONAL RESOURCES TO DEAL WITH THE CONSEQUENCES OF DRUG ABUSE AND THE LACK OF APPROPRIATE RESOURCES TO RESPOND TO IT.

WE HAVE TO ADDRESS THE IMBALANCE IN OUR HEALTH CARE SYSTEM, THE INAPPROPRIATENESS OF A REIMBURSEMENT POLICY THAT IS NON-RESPONSIVE AND SYSTEMATICALLY UNDER PAYS FOR PRIMARY CARE, AND A REGULATORY SYSTEM WHICH HAS PRECLUDED THE DEVELOPMENT OF A POST-ACUTE, AFTERCARE SECTOR.

TO ADDRESS THESE PROBLEMS:

CONGRESS CAN WORK TOWARD INCREASING ACCESS TO THOSE WHO ARE UNINSURED.

CONGRESS CAN REVISE MEDICAID POLICY TO CREATE INCENTIVES FOR PHYSICIANS AND OTHER COMMUNITY HEALTH PROVIDERS TO SERVE MEDICAID PATIENTS.

IN THE 1980'S PUBLIC FUNDS FOR DRUG TREATMENT, PREVENTION AND EDUCATION PROGRAMS WERE REDUCED AT THE EXPENSE OF AN EMPHASIS ON LAW ENFORCEMENT. THERE ARE LONG WAITS FOR TREATMENT FOR THOSE WHO CANNOT PAY FOR PRIVATE CARE IN NEW YORK CITY.

DESPITE WIDESPREAD RECOGNITION THAT PREVENTION AND EDUCATION PROGRAMS BREAK THE CYCLE OF DRUG DEPENDENCE, FEW FEDERAL DOLLARS HAVE BEEN COMMITTED FOR PROGRAMS TO ACHIEVE THIS. MANY COMMUNITIES DO NOT YET HAVE DRUG EDUCATION PROGRAMS, AND EFFORTS TO SERIOUSLY STUDY DRUG-TAKING BEHAVIOR ARE ONLY IN THEIR EARLY STAGES. THERE IS A NEED FOR NEW MODELS, MODELS WHICH ENGAGE THOSE AT RISK IN THEIR HOMES, THEIR SCHOOLS AND THEIR COMMUNITIES.

CONGRESS CAN HELP BY: EXPANDING THE CURRENT FEDERAL RESOURCE COMMITMENT TO THE TREATMENT AND PREVENTION OF DRUG ABUSE, AND

SUPPORTING TREATMENT SERVICES SUCH AS COMMUNITY OUTREACH, CRISIS INTERVENTION AND DRUG-FREE SERVICES THROUGH MEDICAID FUNDING.

THERE ARE ALSO SERIOUS SHORTAGES IN BOTH PRENATAL CARE AND APPROPRIATELY STRUCTURED DRUG TREATMENT CAPACITY FOR WOMEN.

TO ADDRESS THESE PROBLEMS, CONGRESS SHOULD INCREASE FUNDING THROUGH THE MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT, SPECIFICALLY FOR DRUG DEPENDENT WOMEN AND THEIR CHILDREN AND EXTEND MEDICAID COVERAGE TO INCLUDE DRUG TREATMENT SERVICES, AS PART OF THE SERVICES PACKAGE AVAILABLE TO PREGNANT WOMEN THROUGH EXTENDED MEDICAID ELIGIBILITY PROGRAMS OFFERED BY THE STATES (I.e. PACP).

HAVING MORE EDUCATION AND TREATMENT WILL NOT SUFFICE, HOWEVER. THERE HAS BEEN A DEARTH OF RESEARCH INTO TREATMENT METHODS THAT CAN RESPOND TO THE CHANGE IN DRUG USE PATTERNS AND POPULATIONS.

PAGE 10

CONGRESS NEEDS TO APPROPRIATE MORE FUNDING FOR RESEARCH ON WHAT WORKS AND WHAT DOESN'T, PARTICULARLY FOR THE PATIENT GROUPS AND COMMUNITIES WHICH HHC SERVES.

WE ARE CONFRONTED WITH A NATIONAL DISASTER. WE CANNOT RESPOND WITH A FEW PROVISIONS SKIMMED OFF THE FAT OF OTHER NEEDED INITIATIVES. WE MUST DECIDE THAT THIS IS A NATIONAL PRIORITY AND RESPOND QUICKLY, COMPREHENSIVELY AND EFFECTIVELY.

THE DRUG ABUSE EPIDEMIC IS THE NATIONAL DISASTER OF 1990. UNLESS WE TAKE IMMEDIATE ACTION, WE WILL ALL BE DEVASTATED IN ITS WAKE.

DATA REGARDING THE AFFECTS OF DRUG ABUSE ON NYC'S HEALTH CARE SYSTEM AND A DESCRIPTION OF THE TREATMENT PROGRAMS HHC PROVIDES ARE OUTLINED IN THE DOCUMENT ENTITLED **DRUG ABUSE: ISSUES AFFECTING HHC,** WHICH YOU HAVE ALL RECEIVED TODAY.

I WISH TO THANK THIS COMMITTEE FOR TAKING ON THIS PRESSING MATTER. I LOOK TOWARD COMMITTEES AND LEADERS SUCH AS CONGRESSMAN RANGEL TO PROVIDE THE FUNDING, LEADERSHIP AND CREATIVE STRATEGIES TO HELP US RECOVER FROM THE ECONOMIC, SOCIAL AND MEDICAL DEVASTATION THE DRUG EPIDEMIC HAS BROUGHT TO OUR INNER CITIES.

Testimony by Dr. Michelle Reisner,
Director of Emergency Services, Jersey City Medical Center
to the
Select Committee on Narcotics, U.S. House of Representatives
September 28, 1990

Good morning Chairman Rangel and members of the committee. My name is Michelle Reisner and I am the physician-in-charge of emergency services at Jersey City Medical Center. I bring greetings to you from the Medical Center's president, Jonathan Metsch, who formerly served as the senior vice president for administration at the Mount Sinai Medical Center in New York City, which, of course, is in the chairman's district. On behalf of the Medical Center and Dr. Metsch, I would like to publicly thank Congressman Guarini and Hudson County Executive Robert Janiszewski for their continuous support of the institution and for their interest in making sure that the health care needs of the community are met.

Located across the Hudson River from New York City, the Medical Center is an inner city teaching hospital serving a multi-racial population. It also serves a large number of substance abusers, many of whom use the emergency room as their primary care physician, as well as for true emergencies resulting from trauma and urgent illnesses.

The emergency room is on the front line of the drug war. There are 65,000 visits each year to our emergency department. The overwhelming majority are associated with substance abuse. The atmosphere on a typical evening in the emergency room is extraordinary, filled with dramatic efforts to save human life and confront the harsh realities of the street. It is in this environment that the true impact of drugs is experienced.

The cases include drug overdoses, assault and injury victims, abused and neglected children, and babies born addicted to drugs or suffering from withdrawal syndrome. Most alarming are the increasing numbers of drug-related AIDS cases.

The high number of substance abusers in our area -- and in many urban areas --has increased the number of individuals at risk for HIV infection. This relationship between substance abuse and HIV infection is especially clear in New Jersey, where intravenous drug use is the original route of infection in 57 percent of AIDS cases; the national rate is 28 percent. The AIDS epidemic has also hit African-Americans and Hispanics hard in New Jersey. Nationally, 44 percent of all AIDS cases occur in minority groups; in New Jersey minority cases account for 67 percent of the total.

Jersey City is a short train ride from New York City, which is an epicenter of the AIDS crisis, as well as a major distribution site for illicit drugs. This has provided a lethal pathway to infection for many addicts and users in Jersey City, as well as their many non-drug-

using sex partners. This grim picture of the spread of infection and disease is further compounded by the problems of poverty, ignorance and an overburdened, inadequate drug treatment network. In Hudson County, this epidemic has strained the resources of our health care system almost to the breaking point. Last year 57 percent of AIDS admissions in Hudson County were at Jersey City Medical Center. *AIDS patients occupy one in every five medical beds in the Medical Center every day.*

Our hospital provides comprehensive outpatient services to people with AIDS and people at risk for HIV infection. The Medical Center is an active participant in a special federally-funded program which has been in operation for almost one year providing services to intravenous drug abusers. The program provides counseling and referral for drug-abusing AIDS patients. The Medical Center has also applied for federal support for an AIDS Primary Health Care Initiative and funds to construct a long term care unit for persons with AIDS.

In addition to the burden imposed by AIDS and drug abuse, the Medical Center's emergency department is regularly used by local residents for non-emergency care due to their poor access to primary care services. As is typical for urban hospitals, many substance-abusing patients and other low-income and indigent patients come to the emergency room for routine medical care, or when they can't obtain their Methadone dosage, or when they want a hot meal or a safe place to sleep.

The problems are complex and there are no easy solutions. But we must make more of an effort to come to terms with the escalating emergency room and general health care crisis. Our institution is moving forward to establish a 20-bed detoxification unit, but we simply do not have the resources to provide all the services needed by our community. The lack of adequate rehabilitation resources is especially serious for the substantial indigent and uninsured patient population which the Medical Center serves. When substance abusers are discharged after receiving inpatient treatment, there is essentially no place to refer them for rehabilitation and ongoing outpatient treatment.

In general, more attention needs to be devoted to substance abuse education, prevention and rehabilitation, especially for young people and pregnant women.

Without federal support, urban areas like Jersey City, New York, Los Angeles, Baltimore, Oakland, and others cannot meet even the most basic health care needs of their citizens, much less win the war on drugs. If additional funding is appropriated to escalate the war on drugs, I hope that the allocation process recognizes institutions severely affected by these crises.

We also need legislation like H.R. 3630, which the House passed last year, and S. 2649, which has been approved by the Senate Labor Committee. S. 2649 would provide for new funding for a wide range

of drug and alcohol abuse treatment and prevention programs. $75 million of the $250 million authorized would be used for a new grant program to assist drug-addicted women and children. Another important proposal is H.R. 5536, sponsored by Congressman Towns, and its Senate counterpart S. 3002, sponsored by Senators Moynihan and Bradley. This proposal would permit Medicaid coverage of residential drug treatment for pregnant women and their children. These are the kinds of programs that will help our inner cities.

Thank you for this opportunity to share my experiences with you on the impact of drugs and AIDS on urban health care facilities.

TESTIMONY OF MARK CHASTANG

EXECUTIVE DIRECTOR, D.C. GENERAL HOSPITAL

BEFORE THE

HOUSE NARCOTICS COMMITTEE

REPRESENTATIVE CHARLES B. RANGEL, CHAIRMAN

ON

FRIDAY, SEPTEMBER 28, 1990

GOOD AFTERNOON CHAIRMAN RANGEL AND MEMBERS OF THE COMMITTEE. MY NAME IS MARK CHASTANG. I AM THE EXECUTIVE DIRECTOR OF D. C. GENERAL HOSPITAL.

I AM PLEASED TO HAVE THIS OPPORTUNITY TO APPEAR BEFORE YOUR COMMITTEE TODAY TO DESCRIBE TO YOU THE SERIOUS IMPACT OF THE DRUG CRISIS IN WASHINGTON ON D. C. GENERAL HOSPITAL.

FIRST, LET ME TELL YOU A LITTLE BIT ABOUT OUR INSTITUTION AND THE COMMUNITY WE SERVE.

D. C. GENERAL HOSPITAL, IS A 183 YEAR-OLD INSTITUTION THAT STANDS ON THE WEST BANK OF THE ANACOSTIA RIVER, CONTINUING A PROUD TRADITION OF ASSURING THAT DISTRICT OF COLUMBIA CITIZENS -- RECEIVE HEALTH CARE WITH COMPASSION, DIGNITY AND RESPECT.

WE PROVIDE HEALTH CARE SERVICES TO ALL CITIZENS OF THE DISTRICT OF COLUMBIA REGARDLESS OF ABILITY TO PAY. WE ARE ALSO A TEACHING FACILITY WITH AFFILIATIONS WITH GEORGETOWN AND HOWARD SCHOOLS OF MEDICINE.

ANNUALLY, THE HOSPITAL ADMITS MORE THAN 14,000 INPATIENTS, AND PROVIDES APPROXIMATELY 200,000 OUTPATIENT VISITS.

THE SOCIETAL PROBLEM OF SUBSTANCE ABUSE -- SO PERVASIVE ACROSS OUR CITY -- IS ENDEMIC IN OUR PRIMARY SERVICE AREA -- EAST OF THE RIVER. FOR PURPOSES OF MY BRIEF COMMENTS I WILL FOCUS ON THE IMPACT OF THE CURRENT DRUG CRISIS IN THE HOSPITAL'S EMERGENCY ROOM AS IT RELATES TO TRAUMA CARE. ALSO, I WILL BRIEFLY REVIEW THE IMPACT OF DRUGS AS IT RELATES TO THE PHENOMENON OF BOARDER BABIES -- CHILDREN ABANDONED AT THE HOSPITAL BY THEIR PARENTS.

TRAUMA

TRAUMA IS THE LEADING CAUSE OF DEATH AND DISABILITY IN CHILDREN AND YOUNG ADULTS NATIONALLY. SUCH INJURIES REMAIN THE LEADING CAUSE OF DEATH UP TO AGE 44, KILLING MORE AMERICANS AGE 1 - 34 THAN ALL OTHER ILLNESSES COMBINED. FOR PURPOSES OF THIS

CHASTANG TESTIMONY BEFORE RANGEL'S COMMITTEE

PAGE 3

DISCUSSION TRAUMA IS DIVIDED INTO TWO MAIN CATEGORIES, BLUNT AND PENETRATING. BLUNT TRAUMA REFERS TO AUTOMOBILE ACCIDENTS, FALLS, ASSAULTS WITH BASEBALL BATS ETC.; PENETRATING REFERS TO GUNSHOT WOUNDS AND STABBINGS.

D. C. GENERAL PROVIDES AN EXTRAORDINARY AMOUNT OF CARE TO PERSONS WHO ARE TRAUMATIZED. A GREAT DEAL OF ATTENTION HAS BEEN FOCUSED ON THE DRAMATIC INCREASE OF VIOLENCE IN THE DISTRICT IN RECENT YEARS. WE ARE JUSTIFIABLY PROUD OF THE ROLE THAT D. C. GENERAL, AND IN PARTICULAR OUR TRAUMA SERVICE PLAYS IN REDUCING THE LOSS OF LIVES AND THE ALLEVIATION OF PERMANENT DISABILITY.

D. C. GENERAL HOSPITAL WAS DESIGNATED A LEVEL I TRAUMA CENTER IN 1986 BY A TEAM OF LOCAL AND NATIONAL TRAUMA EXPERTS. LEVEL I DENOTES THE HIGHEST TIER IN THE DESIGNATION PROCESS AND IS AWARDED TO TRAUMA CENTERS WITH THE HIGHEST LEVEL OF

COMMITMENT. AS PREREQUISITES, A LEVEL I DESIGNATION CALLS FOR COMPETENT PERSONNEL WHO MUST BE IMMEDIATELY AVAILABLE, STATE OF THE ART EQUIPMENT AND SERVICES, PRIORITY ACCESS TO SOPHISTICATED LABORATORY AND RADIOLOGIC FACILITIES (CT SCAN, ETC.), AS WELL AS, TO THE OPERATING AND INTENSIVE CARE UNITS. A LEVEL I CENTER REQUIRES A STRONG COMMITMENT TO EDUCATION AND RESEARCH AND QUALITY ASSURANCE ACTIVITIES ALL SPECIFICALLY GEARED TO A HIGH LEVEL OF EXCELLENCE IN TRAUMA CARE.

D. C. GENERAL HAS AN ORGANIZED TRAUMA TEAM LED BY AN ATTENDING TRAUMA SURGEON WHICH IS AVAILABLE IN-HOUSE 24 HOURS A DAY FOR THE RECEIPT, STABILIZATION AND DEFINITIVE CARE OF THE TRAUMA PATIENT.

IN THE WAKE OF THE DRAMATIC INCREASE OF VIOLENCE IN THE DISTRICT IN RECENT YEARS OUR TRAUMA SERVICE HAS BEEN TAXED TO THE LIMITS. AT THIS TIME I'D LIKE TO CALL YOUR ATTENTION TO

CHASTANG TESTIMONY BEFORE RANGEL'S COMMITTEE

PAGE 5

GRAPHS I AND II, "TRAUMA CENTER STATISTICS," WHICH SHOWS OUR TRAUMA EXPERIENCE FOR THE LAST SEVERAL YEARS.

APPROXIMATELY 65% OF ALL TRAUMA VICTIMS AT D.C. GENERAL TEST POSITIVE FOR TOXICOLOGY (DRUG TEST) SCREENS. CLEARLY DRUG ABUSE OF ALL KINDS IS A MAJOR CAUSATIVE FACTOR IN THE HOSPITAL'S CURRENT TRAUMA EXPERIENCE. I WILL HIGHLIGHT THE SALIENT POINTS FROM GRAPHS I AND II, "TRAUMA CENTER STATISTICS."

TRAUMA

- Trauma has increased dramatically over the last several years, 1989 and 1990 highest overall.
- Penetrating trauma cases have replaced blunt trauma as the major classification.
- Graph II (Gunshot Wounds), indicates that of the penetrating wounds, gunshots is clearly the largest category and accounts for at least 34% of all trauma for 1989 and 1990.

MATERNAL SUBSTANCE ABUSE

THE SECOND CRITICAL SERVICE WHERE THE CURRENT DRUG EPIDEMIC IS DRAMATICALLY IMPACTING ON D. C.GENERAL HOSPITAL AND OTHER HOSPITALS IS MATERNAL AND CHILD HEALTH SERVICES. WE ARE EXPERIENCING A STEADY INCREASE IN THE NUMBER OF MOTHERS WHO ARE ABUSING DRUGS WHEN PREGNANT. I'D LIKE TO CALL YOUR ATTENTION TO GRAPH III, "PERCENTAGE OF INFANTS BORN TO SUBSTANCE ABUSERS."

AS ILLUSTRATED, DRAMATIC INCREASES HAVE OCCURRED SINCE 1987. WHILE THE NUMBER OF BIRTHS HAVE INCREASED, WE ARE SEEING A SIGNIFICANT RISE IN THE PERCENT OF MOTHERS WHO ARE ABUSING DRUGS DURING PREGNANCY. THIS INCLUDES CRACK, COCAINE AND OTHER DRUGS. THE IMPACT OF THIS PROBLEM IS FAR REACHING. MORE EXPENSIVE AND INTENSIVE MEDICAL CARE IS REQUIRED, AND MOST IMPORTANTLY, MOTHERS ARE ABANDONING THEIR CHILDREN AT BIRTH. OUR STATISTICS INDICATE THAT 90% OF THE BABIES ABANDONED IN THE

HOSPITAL ARE FROM MOTHERS WHO ABUSE DRUGS (CRACK, COCAINE, ETC.) I CALL YOUR ATTENTION TO **GRAPH IV, "DCGH BOARDER BABIES."** THIS IS OUR BOARDER BABY EXPERIENCE FOR THE PAST YEAR.

CONCLUSION

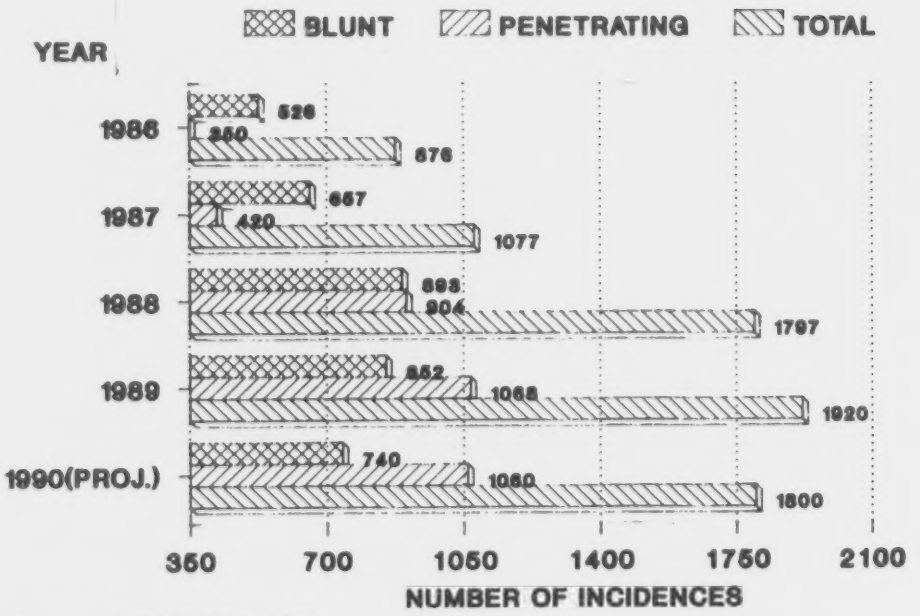
THE CURRENT DRUG EPIDEMIC IS HAVING A DRAMATIC IMPACT ON D.C. GENERAL HOSPITAL.

- o Trauma is up significantly in 1989 and 1990.
- o Mothers are abusing and abandoning their children.
- o Cost to care for these individuals is quite expensive.

IF YOU LOOK FOR A MOMENT AT **GRAPH V, "IMPACT OF SUBSTANCE ABUSE EPIDEMIC ON DCGH OPERATING COSTS,"** YOU WILL SEE THAT THIS YEAR WE ARE SPENDING $26.6 MILLION ON TRAUMA CARE, $4.7 MILLION ON SUBSTANCE ABUSE AND $1.8 MILLION ON BOARDER BABIES.

GRAPH I

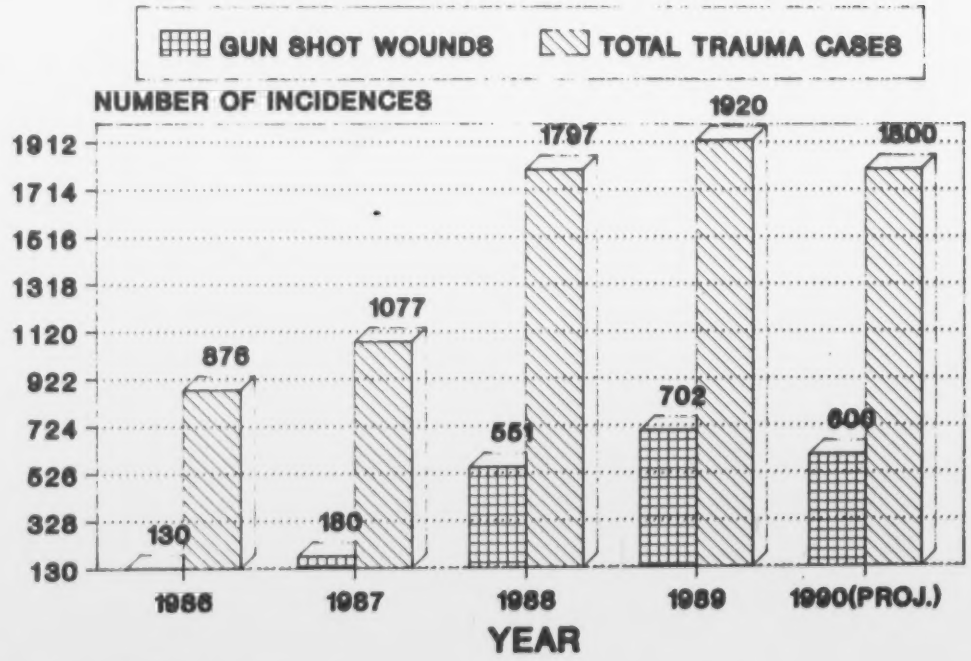
TRAUMA CENTER STATISTICS



DCGH STATISTICS(SEPT. 1990)

GRAPH 11

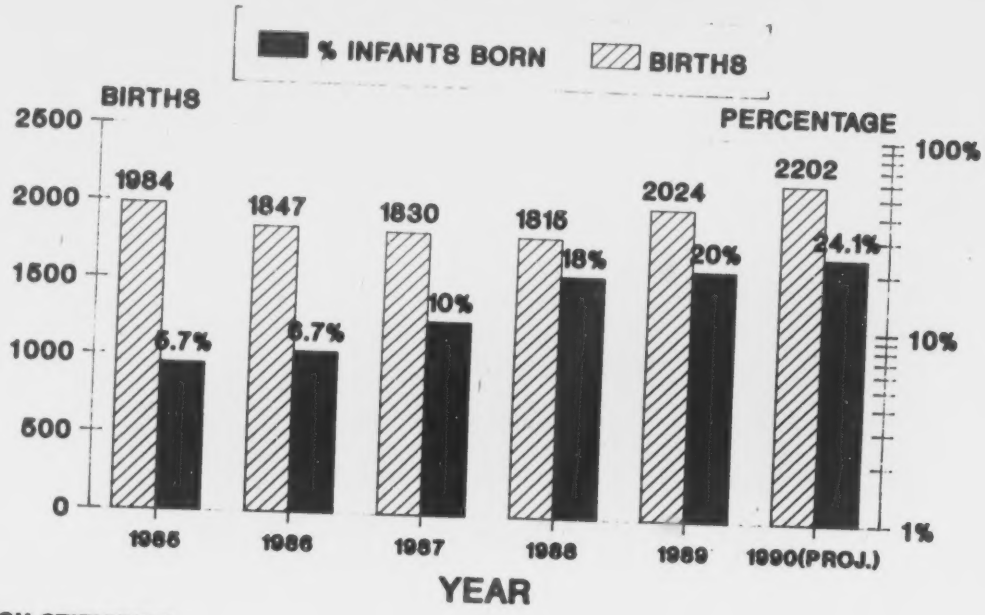
TRAUMA CENTER STATISTICS



DCGH STATISTICS (SEPT. 1990)

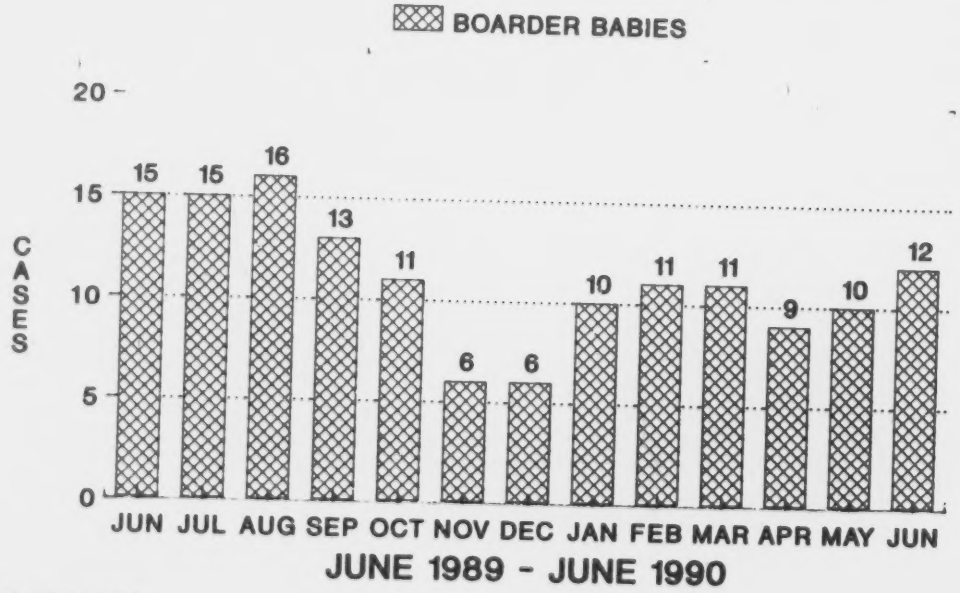
GRAPH III

PERCENTAGE OF INFANTS BORN TO SUBSTANCE ABUSERS



DCGH STATISTICS

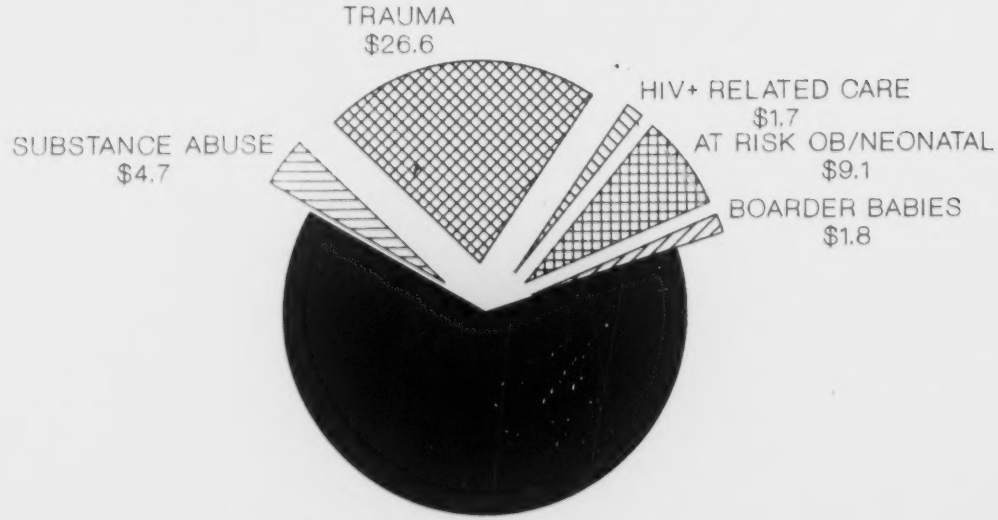
DCGH BOARDER BABIES
NUMBER OF CASES BY MONTH



JUNE 1989 - JUNE 1990

DCGH STATISTICS

IMPACT OF SUBSTANCE ABUSE EPIDEMIC ON DCGH OPERATING COSTS



COST IN $ MILLIONS (FY 1990)